

02666

02657

1. PLACE OF DEATH a. COUNTY <u>AA</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u> <u>Annapolis</u>	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <u>34 Southgate Ave</u>		d. STREET ADDRESS <u>1 34 Southgate Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Louisa Taylor Alger</u>		4. DATE OF DEATH Month <u>3</u> - Day <u>24</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 7-1866</u>
9. AGE (In years last birthday) <u>95</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTH PLACE (State or foreign country) <u>Washington D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Joseph H. Taylor</u>	
14. MOTHER'S MAIDEN NAME <u>Mary M. Meigs</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>-</u>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Philip L. Alger #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>434-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Smoking</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>o. m.</u> Month <u>19</u> Day <u>19</u> Year <u>1962</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1962</u> to <u>March 2, 1962</u> that (I) (we) last saw the deceased alive on <u>March 2, 1962</u> and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>MADRIE F. KLANAWANS</u>		22b. DATE SIGNED <u>31 Southgate Ave</u>	
22c. PHYSICIAN'S NAME (Type) <u>MADRIE F. KLANAWANS</u>		22d. ADDRESS <u>31 Southgate Ave</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-5-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Naval Academy Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Annapolis MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 7 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles E. House</u>			

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The law requires that the death certificate be executed in 24 hours after the death.

Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02667

02658

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN lb <u>1 hour</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL - Millersville</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>AYTCH</u> Last <u>AYTCH</u>		4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>19 62</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 24, 1919</u>	9. AGE (In years last birthday) <u>43</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. <u> </u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Benjamin Brown</u>			
14. MOTHER'S MAIDEN NAME <u>Rose B. Burgess</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or no, or unknown) <u>No</u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>preston Aytch Millersville Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>434.2</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u> DUE TO <u> </u> DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>about 2 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that (I) <u> </u> attended the deceased from <u>August</u> , 19 <u>59</u> , to <u>Mar. 29</u> , 19 <u>62</u> , that (I) <u>(x)</u> saw the deceased alive on <u>Mar. 29, 1962</u> , and that death occurred at <u>1:00 AM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>A. T. Allen</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u> </u>			
22c. PHYSICIAN'S NAME (Type) <u>A. T. Allen, M.D.</u>		22d. ADDRESS <u>62 Cathedral St., Annapolis, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-1-1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hall</u>			
23d. LOCATION (City, town or county) <u>Annapolis Md.</u> (State) <u> </u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>William Keeseff</u> ADDRESS <u> </u>					
25a. REC'D BY REGISTRAR <u>APR 3 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>					

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02668

02659

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>2 Yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Plazor Manor Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Bristol</u> d. STREET ADDRESS <u>Rural</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Agnes</u> Middle <u>Clayton</u> Last <u>Branford</u>				4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>19 62</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>March 8- 1897</u>		9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>*****</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Evans</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hart</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-16-5693</u>		17. INFORMANT Address <u>Annapolis, Md.</u> <u>Thomas E. Simmons-43 College Crk. Terrace</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> <u>715 X</u> DUE TO <u>Septicemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Decubitus Ulcers</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>Hypertensive Cardiovascular Arteriosclerotic Disease, Left CVA.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>1 month.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u>19 62</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1/21/ 1962</u>		20f. (City or town) <u>2/21/ 62</u> (County) <u> </u> (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1/21/ 1962</u> to <u>2/21/ 62</u> that (I) (we) last saw the deceased alive on <u>19 62</u> and that death occurred at <u> </u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Nashel McHenry Jeffs</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>Nashel McHenry Jeffs</u>				22d. ADDRESS <u>20 Dean Street Annapolis, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-27-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>U.S. National</u>		23d. LOCATION (City, town or county) <u>Annapolis, Maryland</u> (State) <u> </u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>C.E. Hicks III</u> ADDRESS <u>Annapolis, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 29 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO BE FILLED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02669

02660

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MAYO		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MAYO		d. STREET ADDRESS *	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) -----				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) J. EARL BRASHEARS				4. DATE OF DEATH Month March Day 8 Year 1962			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1890	9. AGE (in years last birthday) 71 2 1/2 yrs.	IF UNDER 1 YEAR Months 2 Days 1	IF UNDER 24 HRS. Hours 1 Min. 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Painter		10b. KIND OF BUSINESS OR INDUSTRY General-House etc		11. BIRTHPLACE (County & State, or foreign country) Mayo, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Lee Brashears Sr.				14. MOTHER'S MAIDEN NAME Annie Collison			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216 32 7969 A		17. INFORMANT Mrs Margie J. Brashears, Wife same as # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gen carcinoma of 177X DUE TO Ca of prostate Conditions, if any, which gave rise to immediate cause (b) 5 yrs (c), stating the underlying cause last. DUE TO 5 yrs				INTERVAL BETWEEN ONSET AND DEATH 5 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary TB (inactive)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 a.m. 19 p.m.	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 26 , 19 57 to Mar 8 , 19 62 that (I) (we) last saw the deceased alive on 3/7 , 19 62 , and that death occurred at 6:30 AM, from the causes and on the date stated above.							
22a. SIGNATURE S. Borssuck M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED March 9, 1962	
22c. PHYSICIAN'S NAME (Type) S. Borssuck MD				22d. ADDRESS Amos Garrett Blvd, Annapolis, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 11, 1962	23c. NAME OF CEMETERY OR CREMATORY Mayo Memorial		23d. LOCATION (City, town or county) Mayo, Maryland		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME				25a. REC'D BY REGISTRAR DATE MAR 13 '62		25b. REGISTRAR'S SIGNATURE Arthur S. House	

TO ALL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 02661

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>33 Tinkney St.</u>		d. STREET ADDRESS <u>33 Tinkney St.</u>	
3. NAME OF DECEASED (Type or print) <u>Paul Charles Brooks</u>		4. DATE OF DEATH <u>3</u> <u>19</u> <u>1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-28-1892</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secured</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A.A. Co. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jeremiah Brooks</u>		14. MOTHER'S MAIDEN NAME <u>Loisetta Brooks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-32-7518</u>	
17. INFORMANT <u>Mame Camphor - Annapolis, Md.</u>		Address <u>Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4344</u> DUE TO <u>Caloric</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Further</u> DUE TO (c) <u>Further</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Further</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. L. Lohr</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. Lohr</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-25-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Davidsonville</u>	22d. LOCATION (City, town or county) <u>Davidsonville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Geese, D-Corva, Md.</u>		24a. REC'D BY REGISTRAR <u>William G. Thorne</u>	
		24b. REGISTRAR'S SIGNATURE <u>William G. Thorne</u>	

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CHIEF OF POLICE

AND



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THE AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02671

02662

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN IB <u>6 years</u> 16 mos. 24 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>576 Baker Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>Mae</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>3</u> Day <u>22</u> Year <u>1962</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 21, 1878</u>	
9. AGE (In years last birthday) <u>83</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> M'n. <u> </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11c. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Hardy</u>		14. MOTHER'S MAIDEN NAME <u>Georgiana Pipes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ruptured Aortic Aneurysm, Arteriosclerotic</u> 451X Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last, (c) <u> </u> DUE TO <u> </u> DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> e.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>4/7</u> <u>1952</u> <u>to</u> <u>3/22</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>3/22</u> <u>1962</u> , and that death occurred on <u>3/22</u> <u>1962</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Lionel McHenry Mapp</u> M.D.		22b. DATE SIGNED <u>3/22/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/28/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>mt Auburn Cem.</u>		23d. LOCATION (City, town or county) <u>Baltimore</u> (State) <u>Ind.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert E. Snutter</u> ADDRESS <u>3035 W. North</u>		25a. REC'D BY REGISTRAR <u>Art</u> DATE <u>MAR 27 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>		25c. REGISTRAR'S NAME <u>Arthur L. Harris</u>	

TO MAIL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02672
CERTIFICATE OF DEATH
02663

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riva c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Riverview Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Davidsonville d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROSA M BROWN		4. DATE OF DEATH Month March Day 28 Year 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 11, 1873	
9. AGE (in years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		11b. KIND OF BUSINESS OR INDUSTRY own home	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Gaither	
14. MOTHER'S MAIDEN NAME Harriett Stockett		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) none	
16. SOCIAL SECURITY NO none		17. INFORMANT Mrs James W. Suit- Daughter- same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 422 DUE TO Cerebral hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 10 days 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 1945 to Mar 28, 1962 , that (I) (we) last saw the deceased alive on Mar 27, 1962 , and that death occurred at 5:00 AM , from the causes and on the date stated above.			
22a. SIGNATURE S. Borssuck			
22b. DATE SIGNED March 29, 1962			
22c. PHYSICIAN'S NAME (Type) S. Borssuck M D			
22d. ADDRESS Amos Garrett Blvd. Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF March 31, 1962			
23c. NAME OF CEMETERY OR CREMATORY Davidsonville Methodist			
23d. LOCATION (City, town or county) (State) Davidsonville, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home			
25a. REC'D BY REGISTRAR APR 2 '62			
25b. REGISTRAR'S SIGNATURE Charles S. Thomas			

02673

CERTIFICATE OF DEATH

02664

Item 9 Film 6310 4/5/62 mh

1. PLACE OF DEATH a. COUNTY Anne-Arundel		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN b 3 Days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne-Arundel		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgewater		d. STREET ADDRESS Turkey Point, Route 1		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mozelle Bridges		4. DATE OF DEATH March 30 19 62		5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6 October 1918		9. AGE (in years last birthday) 42/43		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife	
11. BIRTHPLACE (County & State, or foreign country) Orange, North Carolina		12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Miles (n) BRIDGES		14. MOTHER'S MAIDEN NAME Annie Bell LINK		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. MAJ. JOHN K. BULLOCK		17. INFORMANT Box 428 K4 RT 1 EDGEWATER MD.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170 X		DUE TO Hepatic Cancer		CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hepatic metastases		DUE TO Carcinoma of breast.		INTERVAL BETWEEN ONSET AND DEATH 3/29/62-3/30 3/10/62-3/30 5/2/60-3/30		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Edgewater		20g. (County) Anne-Arundel		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 28 March 1962 to 30 March 1962 , that (I) (we) last saw the deceased alive on 30 March 1962 end that death occurred at 12:39 PM , from the causes and on the date stated above.		22a. SIGNATURE S.B. HILTBIDLE LCDR MC USNR		22b. DATE SIGNED 30 MAR 62		22c. PHYSICIAN'S NAME (Type) S.B. HILTBIDLE		22d. ADDRESS U.S. NAVAL HOSPT. ANNAPOLIS MD.		22e. REC'D BY REGISTRAR APR 2 '62		22f. REGISTRAR'S SIGNATURE William S. Hume		22g. DATE APR 2 '62	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-3-1962		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT. CEM.		23d. LOCATION (City, town or county) ARLINGTON VA.		23e. LOCATION (State) VA.		23f. FUNERAL DIRECTOR'S SIGNATURE JOHN M. TAYLOR SON ANNAPOLIS MD.		23g. ADDRESS ANNAPOLIS MD.		23h. REC'D BY REGISTRAR APR 2 '62	

MEDICAL CERTIFICATION

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02674

02665

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institut on; Residence before admission) e. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 205 N. 4th Street	
3. NAME OF DECEASED (Type or print) First Etta Middle Victoria Last Burrell		4. DATE OF DEATH Month 3 Day 11 Year 1962	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 3, 1879
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crab Picker		9b. AGE (In years last birthday) 82 yrs.	
10a. BIRTHPLACE (County & State, or foreign country) Massachusetts		11. BIRTHPLACE (County & State, or foreign country) Massachusetts	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Oscar Waters	
14. MOTHER'S MAIDEN NAME Annie Tilgham		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No	
16. SOCIAL SECURITY NO. 215-07-2439		17. INFORMANT Hospital Records	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20c. TIME OF INJURY Hour 19 e.m. p.m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) factory street	20f. (City or town) Crisfield	(County) Somerset	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from 7/1 to 3/11 , 19 62 , that (I) (we) last saw the deceased alive on 3/11 , 19 62 , and that death occurred at 8 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Hildegard Heard Reissman			22b. DATE SIGNED 3/12/62		
22c. PHYSICIAN'S NAME Hildegard Heard Reissman, M. D.			22d. ADDRESS Crownsville State Hospital, Maryland		

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/16/ 1962	23c. NAME OF CEMETERY OR CREMATORY MT. Calvary	23d. LOCATION (City, town or county) Fruitland Md.
24. FUNERAL DIRECTOR'S SIGNATURE Clinton Stewart Salisbury Md		25a. REC'D BY REGISTRAR DATE MAR 15 '62	25b. REGISTRAR'S SIGNATURE Colonel S. Kenna

1. The law requires that the death certificate be examined within 24 hours after death. The law requires that the death certificate be examined within 24 hours after death. The law requires that the death certificate be examined within 24 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02675 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02666

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN 1b few minutes d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sanitary Commision Building, Baltimore, Annapolis Blvd.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn d. STREET ADDRESS Severn	
3. NAME OF DECEASED (Type or print) William Bussey First Middle Last William Bussey		4. DATE OF DEATH Month Day Year 3/1/62 19	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 Aug. 1882 79 yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer and minister.		11. BIRTHPLACE (State or foreign country) Germany	
13. FATHER'S NAME August Bussey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Robert Bussey - Severn, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town, (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gustave H. Faubert, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE 3/5/62 Address (Street, city, town, or county) Glen Burnie, Md.	
22b. BURIAL, CREMATION, REMOVAL (Specify) Burial	22c. DATE THEREOF 5 March 62	22d. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery	22e. LOCATION (City, town, or country) (State) Glen Burnie - Md.
23. FUNERAL DIRECTOR Robert P. Ware - Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE MAR 7 '62	
		24b. REGISTRAR'S SIGNATURE William E. Hines	

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please see the instructions on the reverse side of this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02668

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) X STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Broad Creek - Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Broad Creek South River</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Broad Creek (Nr. Annapolis)</u>		d. STREET ADDRESS <u>Annapolis R.F.D.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES REVELL CARR</u>		4. DATE OF DEATH Month Day Year <u>3 22 1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 28 1890</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Surveyor</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Surveyor</u>	
13. FATHER'S NAME <u>MAYNARD CARR</u>		14. MOTHER'S MAIDEN NAME <u>HARRIETT DORSEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>W.W.I</u>	
17. INFORMANT <u>Eva Dorsey Carr Gasperich</u>		Address <u>Crownsville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cause</u> DUE TO (c) <u>Interval between onset and death</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-27-1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Stephens Court</u>		22d. LOCATION (City, town, or county) (State) <u>Millersville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		ADDRESS <u>Annapolis Md</u>	
24a. REC'D BY REGISTRAR <u>MAR 27 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thum</u>	

DATE SIGNED
3/25/62

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

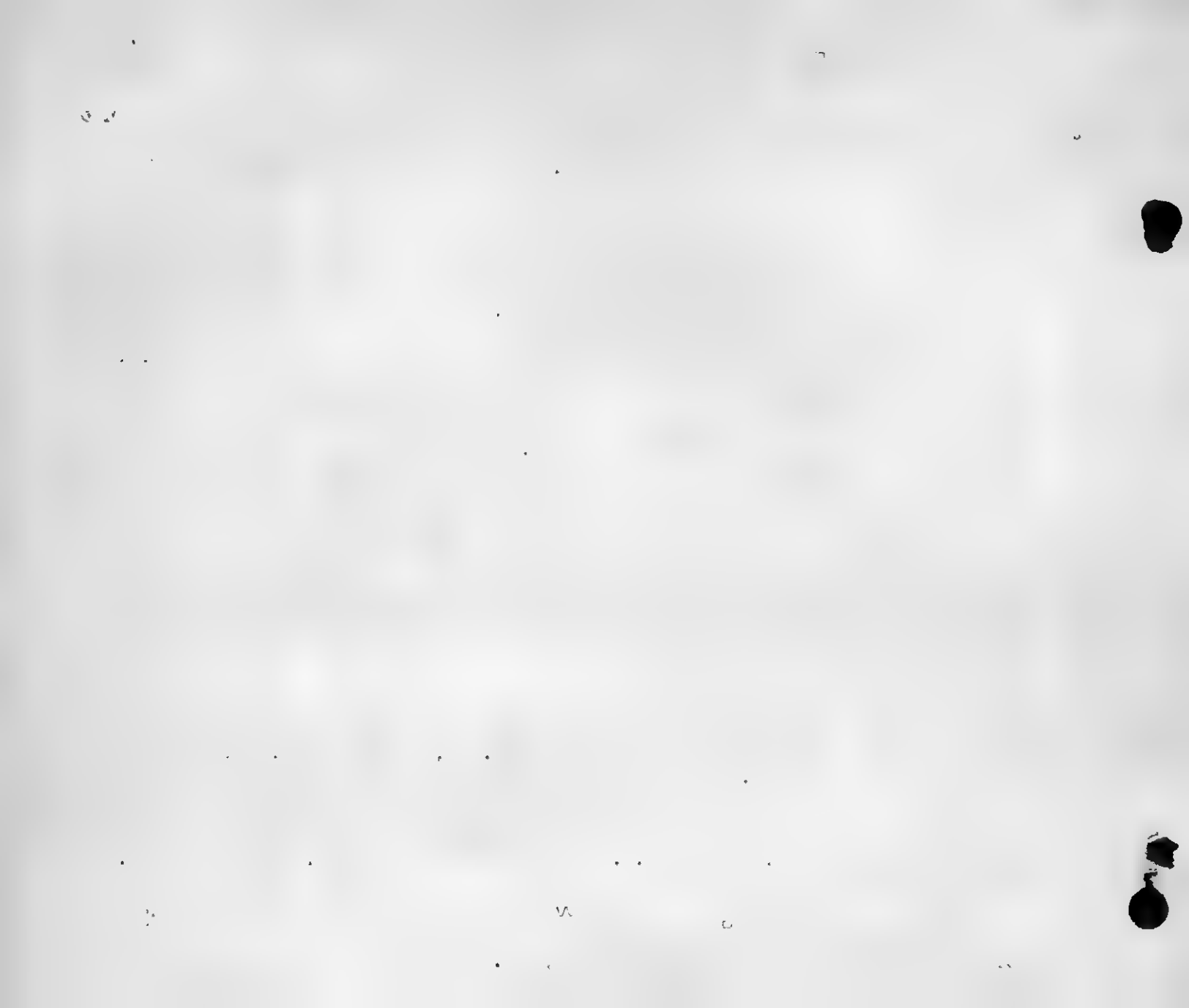
02678

02669

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>1 mo. 16 da.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Gambrills</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Georgeanna</u> Middle <u>CHANCE</u> Last <u>March</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>Sept. 13, 1889</u> 9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.		4. DATE OF DEATH <u>March 15 19 62</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret)</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Tucker</u> 14. MOTHER'S MAIDEN NAME <u>Alice Ridgeway</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT <u>Mrs. Melvia Salyers</u> Address <u>Same As #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Peripheral Arterial Collapse</u> (b) <u>Arteriosclerotic Cardiovascular Disease</u> (c) <u>1 year</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (M.D. or other qualified person) attended the deceased from Jan. 27, 1962, to Mar. 15, 1962, that (I) (M.D. or other qualified person) saw the deceased alive on Mar. 15, 1962, and that death occurred at 8:52 AM, from the causes and on the date stated above. 22a. SIGNATURE <u>Richard N. Peeler</u> M.D. 22b. DATE SIGNED <u>3/15/62</u> 22c. PHYSICIAN'S NAME (Type) <u>Richard N. Peeler, M.D.</u> 22d. ADDRESS <u>121 Cathedral St., Annapolis, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>19th March 62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Glen Burnie Mem. Park</u> 23d. LOCATION (City, town or county) <u>Glen Burnie, Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Hanna</u> 25a. REC'D BY REGISTRAR <u>Arthur S. Hanna</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u> DATE <u>MAR 19 '62</u>	

MEDICAL CERTIFICATION

ORIGINAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02679

02670

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN IB 1 year 8 mos. 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 1820 Woodyear Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Collins		4. DATE OF DEATH Month Day Year 3 31 1962		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH August 22, 1892		9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days 19 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Maryland and	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Collins		14. MOTHER'S MAIDEN NAME Lavinia Nelson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Chronic Brain Syndrome Associated with Senile Brain Disease</u> (a), stating the underlying cause last, (c) <u>Chronic Brain Syndrome Associated with Senile Brain Disease</u> DUE TO PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH			
20a. TIME OF INJURY Hour e.m. p.m. 19		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) -----	
20d. (City or town) -----		20e. (County) -----		20f. (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 7/15 1969, to 3/31 1962, that (I) (we) last saw the deceased alive on 3/31 1962, and that death occurred at 3:15 P.M. from the causes and on the date stated above.		22a. SIGNATURE L. Benedict, M. D.		22b. DATE SIGNED 4/2/62	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland		22e. DATE SIGNED 4/2/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-6-62		23c. NAME OF CEMETERY OR CREMATORY Mt Auburn	
23d. LOCATION (City, town or county) Mt Auburn		23e. (State) -----		23f. (Country) -----	
24. FUNERAL DIRECTOR'S SIGNATURE Geo. S. Talson		24b. ADDRESS 1348 W. Calhoun St		25a. REC'D BY REGISTRAR APR 5 '62	
25b. REGISTRAR'S SIGNATURE William S. Thomas		25c. DATE APR 5 '62		25d. (State) -----	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. Its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02671

1. PLACE OF DEATH a. COUNTY <u>Deale, Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>									
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 		d. STREET ADDRESS <u>8916 FAIRVIEW RD.</u>									
3. NAME OF DECEASED (Type or print) <u>Henry</u>		4. DATE OF DEATH Month <u>3</u> Day <u>3</u> Year <u>1962</u>									
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>									
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 3 1917</u>									
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACCOUNTANT</u>		9b. AGE (In years last birthday) <u>45</u> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACCOUNTANT</u>		10b. KIND OF BUSINESS OR INDUSTRY 									
11. BIRTHPLACE (State or foreign country) <u>KENTUCKY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>									
13. FATHER'S NAME <u>BALLARD F. COMBS</u>		14. MOTHER'S MAIDEN NAME <u>MARY CORNETT</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>404-10-9523</u>									
17. INFORMANT <u>WILMA Y. COMBS</u>		Address <u>8916 FAIRVIEW RD</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to</u> <u>drowning</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>Occlusive arteriosclerotic heart disease</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No visible injury</u>									
20c. TIME OF INJURY Month, Day, Year <u>March 2, 1962</u> Hour <u>or</u> <u>p.m.</u> <u>Mar. 3, 1962</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hippis Marine, Deale</u>		20f. (City or town) (County) (State) <u>Ar. Md.</u>									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>R. Breitenacher</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>3/4/62</u>									
EXAMINER'S NAME (Type) 		Address (Street, city, town, or county) 									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR. 6 1962</u>									
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L CEM.</u>		22d. LOCATION (City, town, or country) (State) <u>ARLINGTON</u> <u>VA.</u>									
23. FUNERAL DIRECTOR <u>WARNER E. PUMPHREY, INC.</u>		24a. REC'D BY REGISTRAR <u>DATAAR 5 02</u>									
24b. REGISTRAR'S SIGNATURE <u>1 S. Thomas</u>											



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02682

02673

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Maple Road				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie d. STREET ADDRESS 1200 Wilson Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lee Middle H. Last Cope		4. DATE OF DEATH Month March Day 30 Year 1962		5. SEX male			
6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 4, 1889			
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Owner		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (County & State, or foreign country) Nashville, Tenn			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Martin VanBuren Cope					
14. MOTHER'S MAIDEN NAME Betty Richason				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			
16. SOCIAL SECURITY NO. 217-16-7826				17. INFORMANT Robert J. Cope, 1200 Wilson Road, Glen Burnie			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Disease DUE TO (b) Arteriosclerosis & Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) - 10 y. - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from....., 1946 to 3/30, 1962, that (I) (we) last saw the deceased alive on 3/31/62, and that death occurred at 10 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Charles L. Ball, Jr.				22b. DATE SIGNED APR 3 '62			
22c. PHYSICIAN'S NAME (Type) Charles L. Ball, Jr. M.D.				22d. ADDRESS 203 Maple Road, Linthicum, Md			
23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		23b. DATE THEREOF 4-2-62		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery			
23d. LOCATION (City, town or county) Anne Arundel County, Md		23e. STATE					
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Baltimore 2				25a. REC'D BY REGISTRAR APR 3 '62			
25b. REGISTRAR'S SIGNATURE Arthur J. Hines				25c. ADDRESS			

TO SPECIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

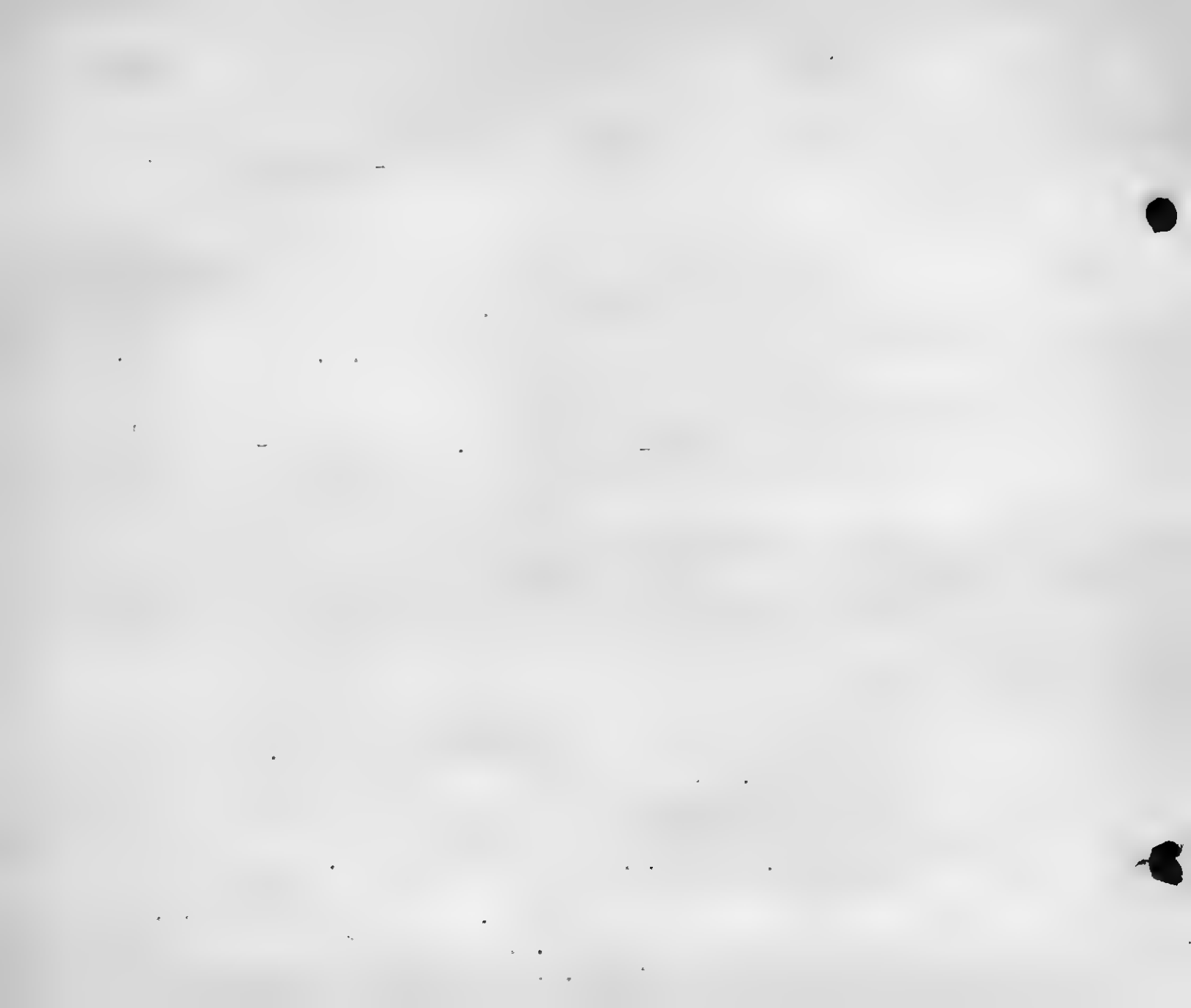
VR A15 (4)
 15M 9/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02683
02674
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b 16 hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - Edgewater d. STREET ADDRESS Woodland Beach e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John First Middle Last COSTELLO		4. DATE OF DEATH Month Day Year March 14 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sep. 18, 1897
9. AGE (In years last birthday) 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender	11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Timothy Costello	
14. MOTHER'S MAIDEN NAME Nora Moran		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 577-03-8103		17. INFORMANT Son Address Laurel, Md. John J. Costello 1102- Montrose St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver failure and hemorrhage from ulceration of neck Conditions, if any, which gave rise to immediate cause (b) Carcinoma of larynx & metastases to neck nodes and liver (c) 161 X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) 12 months or longer		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour e.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) March 9, 1962	
20f. (City or town) Mar. 14, 1962		20g. (County) Washington, D.C.	
20h. (State) Washington, D.C.		21. I certify that (I) Willard F. Smith attended the deceased from March 9, 1962 to March 14, 1962 , that (I) Willard F. Smith saw the deceased alive on March 14, 1962 , and that death occurred at 8:15 AM from the causes and on the date stated above.	
22a. SIGNATURE Willard F. Smith		22b. DATE SIGNED 3/14/62	
22c. PHYSICIAN'S NAME (Type) Willard F. Smith, M.D.		22d. ADDRESS Shadyside, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/17/62	
23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cem.		23d. LOCATION (City, town or county) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		25a. REC'D BY REGISTRAR MAR 16 '62	
25b. REGISTRAR'S SIGNATURE Charles S. House		25c. ADDRESS 300-4th Street N.E. Washington D.C.	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) P.O. Arnold d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. 3, Box 324, Deep Creek		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Same c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same d. STREET ADDRESS Same	
3. NAME OF DECEASED (Type or print) William McNeal Covington		4. DATE OF DEATH Mar. 18 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/15/13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		11. BIRTHPLACE (State or foreign country) Tilghman, Md.	
13. FATHER'S NAME Thomas F. Covington		14. MOTHER'S MAIDEN NAME Margerite Haddaway	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		17. INFORMANT Mrs. Pauline H. Covington (Wife)	
16. SOCIAL SECURITY NO. No		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) Sudden PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gustave H. Faubert		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gustave H. Faubert, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22b. BURIAL, CREMATION, REMOVAL (Specify) Burial		22c. NAME OF CEMETERY OR CREMATORY St. John Cemetery	
22b. DATE THEREOF 3-21-62	22c. LOCATION (City, town, or country) (State) Tilghman Md	DATE Mar. 18, 1962	
23. FUNERAL DIRECTOR L. Hamilton Harrison, St. Michaels		24a. REC'D BY REGISTRAR Mar 23 1962	
ADDRESS St. Michaels		24b. REGISTRAR'S SIGNATURE Arthur S. H. H.	

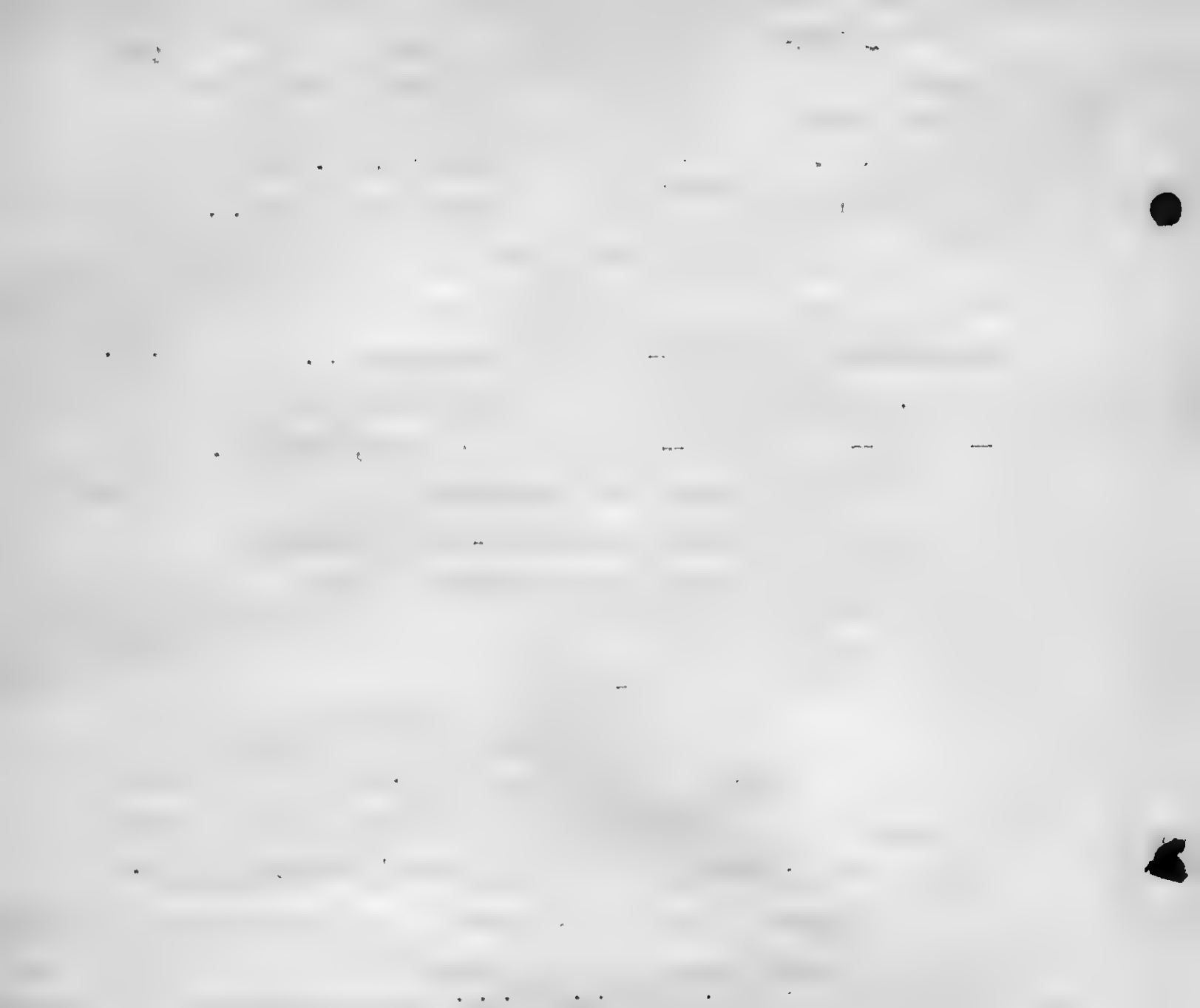
MEDICAL CERTIFICATION

TO BE FILLED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 115 (4)
15M 9/60

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11
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02676
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
c. LENGTH OF STAY in 1b 4 years		d. STREET ADDRESS 1811 Kilbourne Place N.W.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) District Training School Children's Center		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Raymond Last Cronin		4. DATE OF DEATH Month 3 Day 4 Year 1962	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 12/12/46		9. AGE (In years last birthday) 15 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Institutionalized		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John K. Cronin		14. MOTHER'S MAIDEN NAME Mary Fitzgerald	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) --		16. SOCIAL SECURITY NO. --	
17. INFORMANT Children's Center, Laurel, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Spastic quadriplegia - convulsive disorder DUE TO (c) Severe mental retardation		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). --		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) --		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/31/58 to 3/4/62 , that (I) (we) last saw the deceased alive on 3/4/62 , and that death occurred at 1:12 PM from the causes and on the date stated above.			
22a. SIGNATURE James E. Boyland		22b. DATE SIGNED 3/5/62	
22c. PHYSICIAN'S NAME (Type) James E. Boyland		22d. ADDRESS Children's Center, Laurel, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/6/1962	
23c. NAME OF CEMETERY OR CREMATORY MOUNT OLIVET CEMETERY		23d. LOCATION (City, town or county) (State) WASHINGTON, DISTRICT OF COLUMBIA	
24. FUNERAL DIRECTOR'S SIGNATURE Hyson Funeral Home		25. REC'D BY REGISTRAR Hyson Funeral Home	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas		25c. DATE MAR 7 '62	
HYSON FUNERAL HOME-1300 N. STREET, N.W.-WASH. D.C.			



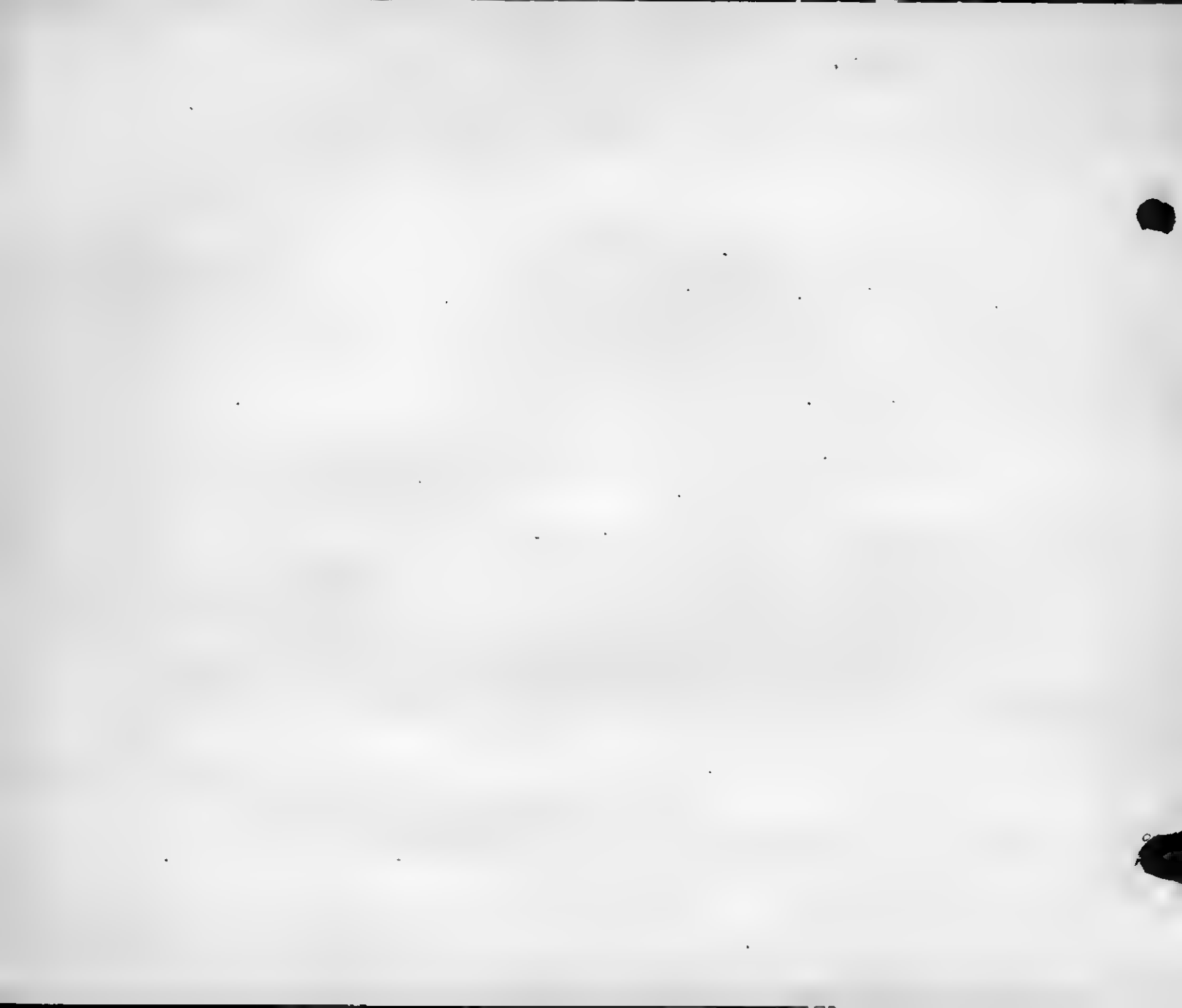
02686

02677

1. PLACE OF DEATH a. COUNTY <i>aa</i>				2. USUAL RESIDENCE (Where deceased lived; if institution; Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>aa</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1201 West St.</i>				d. STREET ADDRESS <i>1201 West St</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Edward</i> Middle <i>M.</i> Last <i>Davis</i>				4. DATE OF DEATH Month <i>3</i> Day <i>24</i> Year <i>1962</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 12 - 1886</i>	9. AGE (In years last birthday) <i>75</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Carpenter</i>		11. BIRTHPLACE (State or foreign country) <i>Bwa Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Henry Davis</i>				14. MOTHER'S MAIDEN NAME <i>Mellie Redmond</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Lida S. Davis</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Crown Cardiac Failure</i> DUE TO (b) <i>Myocarditis</i> DUE TO (c) <i>Cancer of Prostate</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							INTERVAL BETWEEN ONSET AND DEATH <i>about 2 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <i>9</i> a. m. <i>11</i> p. m. Month <i>Nov</i> Day <i>7</i> Year <i>1958</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>911 Nov</i>		20f. (City or town) <i>Annapolis</i>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>9-11 Nov 1958</i> to <i>3-24-1962</i> that (I) (we) last saw the deceased alive on <i>3-24-1962</i> and that death occurred at <i>7:25 P</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>J. Oliver Purvis</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>J. Oliver Purvis, M.D.</i>				22d. ADDRESS <i>10 Franklin St., Annapolis, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Mar 27-62</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest Cemt</i>		23d. LOCATION (City, town, or county) <i>Annapolis Md</i>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Saylor Sons Annapolis Md</i>				25a. REC'D BY REGISTRAR DATE <i>MAR 27 '62</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	

TO HOSPITAL: YOUR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

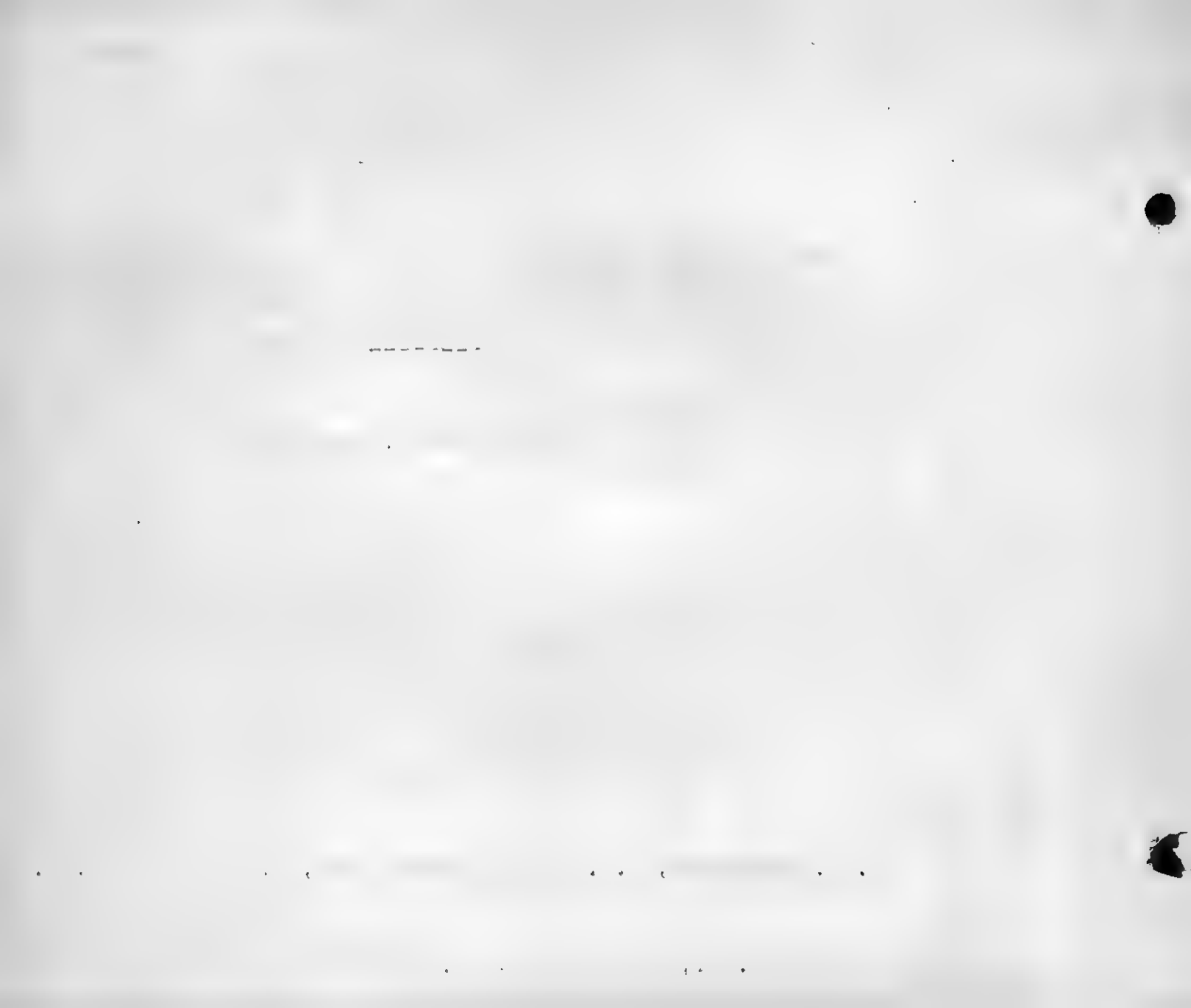
02687

CERTIFICATE OF DEATH

02678

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Linthicume		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
c. LENGTH OF STAY IN 1b 10 Days		d. STREET ADDRESS 822 Dale Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 31 Milton Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Norah Deline Dekle		4. DATE OF DEATH Month Day Year 3 12 1962	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/21/02
9 AGE (In years lost birthday) yrs 59		10. IF UNDER 1 YEAR Months Days Hours Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown Gillette		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Arthur Dekle, Same as 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Uterus c Metastasis DUE TO 74 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 Mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-16 , 19 62 to 3-12 , 19 62 that (I) (we) last saw the deceased alive on 3-11 , 19 62 and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE C. R. MacDonald M.D.		22b. DATE SIGNED 3-13-62	
22c. PHYSICIAN'S NAME (Type) C. R. MacDonald, M.D.		22d. ADDRESS 204 Crain Hwy, SW, Glen Burnie, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/17/62	23c. NAME OF CEMETERY OR CREMATORY Dorchester	23d. LOCATION (City, town, or county) (State) Lab. P. T. Co. 117
24. FUNERAL DIRECTOR'S SIGNATURE Hopping & Kirkley F. H.		25a. REC'D BY REGISTRAR DATE MAR 16 '62	
ADDRESS Glen Burnie, Md.		25b. REGISTRAR'S SIGNATURE C. L. S. H. H. H.	

MEDICAL CERTIFICATION



1. **FINAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

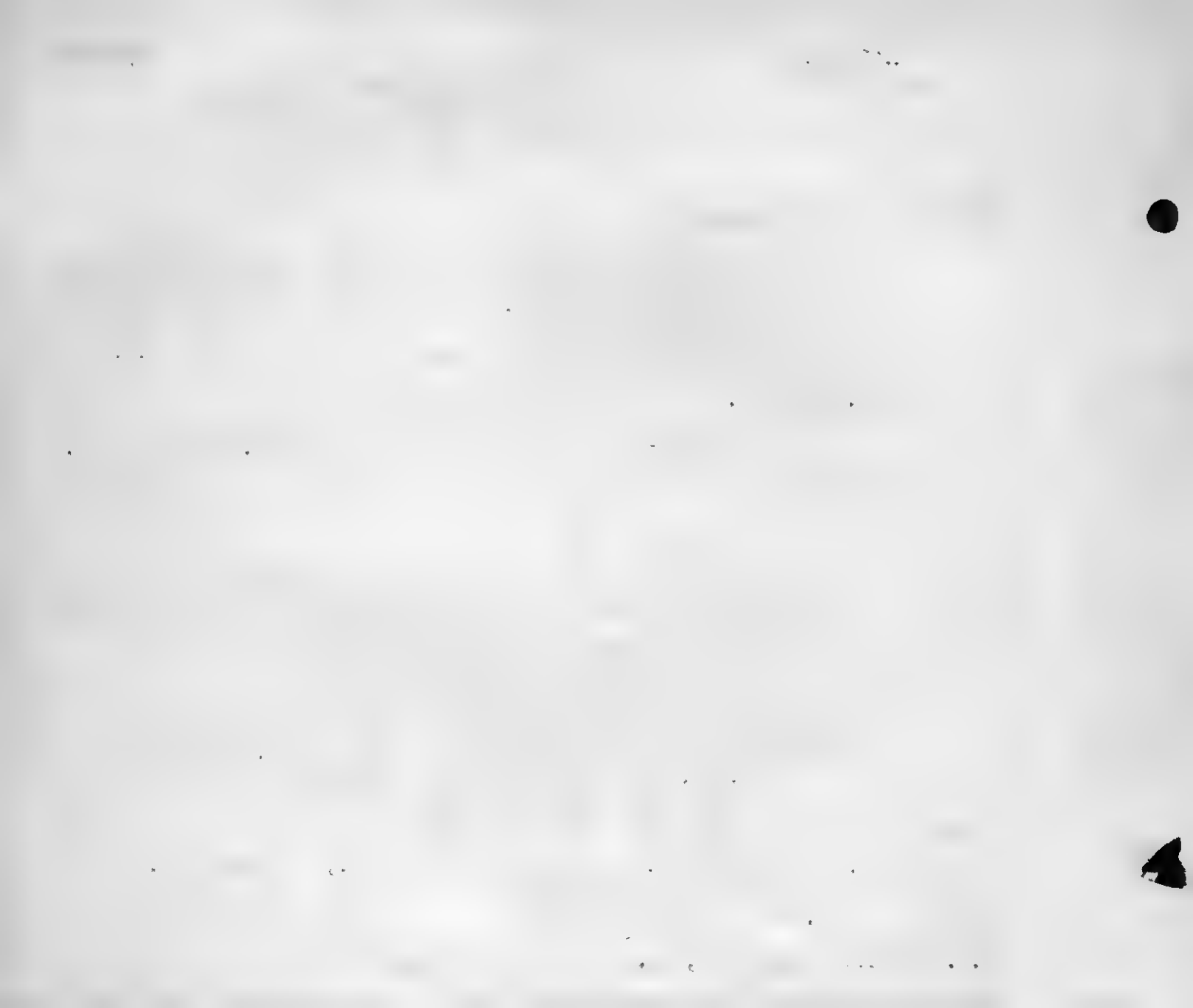
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02688

02679

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN b <u>7 Years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u> (Dead on arrival)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>901 Spa Road</u>		3. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH <u>March 15 1962</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 30, 1915</u>		9. AGE (In years last birthday) <u>46 yrs.</u> IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>George E. Diggs Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Thomas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-12-5152</u>		17. INFORMANT <u>Beulah W. Diggs-901 Spa Rd. Annapolis, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> <u>Coronary Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 hr</u> <u>3 pm</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (the doctor) attended the deceased from 19 to Mar. 15, 1962 that (I) (we) last saw the deceased alive on Mar. 15, 1962, and that death occurred at 3:10 PM from the causes and on the date stated above.					
22a. SIGNATURE <u>Herbert H. Johnson M.D.</u>		22b. ADDRESS <u>37 Calvert St., Annapolis, Md.</u>		22c. PHYSICIAN'S NAME (Type) <u>T. H. Johnson, M.D.</u>	
22d. DATE <u>3/16/62</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 18-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial</u>	
23d. LOCATION (City, town or county) <u>Laural Maryland</u>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>C.E. Hicks III</u>		ADDRESS <u>Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 23 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>					



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

02689

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02680

1. PLACE OF DEATH
a. COUNTY

H H CO.

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

RURAL

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

ANN ARUNDEL GENERAL

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

John

Donnell
VPM 4/4/41

4. DATE OF DEATH

Month

Day

Year

3

5

1962

5. SEX

M

6. COLOR OR RACE

C

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

3-26-84

9. AGE (In years last birthday)

77

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

BIRTHPLACE (State or foreign country)

Maryland

11. FATHER'S NAME

Unknown

11. MOTHER'S MAIDEN NAME

Mary Chambers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service)

NO

16. SOCIAL SECURITY NO.

216-185643

17. INFORMANT

Estella Neal

Address

Rt 1 Box 453 Edgewater Md

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

473

X DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

Septicemic Cardiovascular disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a)

INTERVAL BETWEEN ONSET AND DEATH

5 MIN

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Hour a.m.

Month, Day, Year

19

20d. INJURY OCCURRED

While at work

Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

John F. L. H. H. H.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

EXAMINER'S NAME (Type)

FLIN H. H. H.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

3-8-1962

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

William Reese # Anna Mc

DATE

MAR 9 '62

Arthur S. Hines

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02690

02681

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>5500 Fernpark Avenue</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH</u> <u>WILLIAM</u> <u>Joseph DORE</u>				4. DATE OF DEATH Month Day Year <u>March</u> <u>20</u> <u>19 62</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>3/31/12</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Solicitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sunpapers</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		9. AGE (In years last birthday) <u>49</u> yrs.	
13. FATHER'S NAME <u>James Francis Dore</u>		14. MOTHER'S MAIDEN NAME <u>Mary Geaney</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes 1-20-42-1-24-46</u>	
16. SOCIAL SECURITY NO. <u>110-05-8048</u>				17. INFORMANT <u>Mary G. Dore 5500 Fernpark Avenue</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Traumatic Injuries.</u> <u>8/11 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> DUE TO (c), stating the underlying cause last. (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver in auto-truck collision.</u>							
20c. TIME OF INJURY Month, Day, Year <u>3/20/62</u> Hour <u>9</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>				20f. (City or town) (County) (State) <u>Anne Arundel Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles S. Petty</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Charles S. Petty, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3-26-62</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore, National</u>				22d. LOCATION (City, town, or country) (State) <u>Baltimore, Maryland</u>			
23. FUNERAL HOME <u>Ellsworth Armacost 4600 Liberty Heights Ave.</u>				24a. REC'D BY REGISTRAR <u>MAR 23 '62</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 11 years 7 mos. 23 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1204 Young's Court	
3. NAME OF DECEASED (Type or print) Ida First Middle Last Falks		4. DATE OF DEATH Month Day Year 3 21 1962	
5. SEX Female 6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH March 15, 1888 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----	
13. FATHER'S NAME Unknown		11. BIRTHPLACE (County & State, or foreign country) Virginia	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. Unknown		14. MOTHER'S maiden name Unknown	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE Carcinoma of Pancreas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work While <input type="checkbox"/> at work	
21. I certify that (I) (this hospital) attended the deceased from 7/28 19 50 to 3/21 1962 , that (I) (we) last saw the deceased alive on 3/21 1962 , and that death occurred at 7:55 a.m. from the causes and on the date stated above.		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
22a. SIGNATURE Lionel McHenry Mapp, M. D.		20f. (City or town) Crownsville (County) Maryland (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 30, 1962	
24. FUNERAL DIRECTOR'S SIGNATURE Charles S. Ward, M.D.		25a. REC'D BY REGISTRAR APR 3 '62	
25b. REGISTRAR'S SIGNATURE Charles S. Ward		25c. NAME OF CEMETERY OR CREMATORY C.S.H. Burial Grounds	
25d. LOCATION (City, town or county) Crownsville		25e. REGISTRAR'S SIGNATURE Charles S. Ward	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

Item 10 Fill in 511 4-1-1

1

M

02692

02683

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY AA **MARYLAND**
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 14 **1b**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 12 Francis St.

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE Md b. COUNTY AA
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis Md.
d. STREET ADDRESS 176 Shipwright St
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Helen Farrell **DATE OF DEATH** Mar 28 1962
First Middle Last Day Month Year

5. SEX Female **6. COLOR OR RACE** White **7. MARRIED** ☐ **NEVER MARRIED** ☒ **8. DATE OF BIRTH** Aug 26-1888
9. AGE (In years last birthday) 73 yrs. **IF UNDER 1 YEAR** Months Days **IF UNDER 24 HRS.** Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper at National Bank **10b. KIND OF BUSINESS OR INDUSTRY** Annapolis Md **11. BIRTHPLACE** (County & State, or foreign country) U.S.A. **12. CITIZEN OF WHAT COUNTRY?** U.S.A.

13. FATHER'S NAME James Farrell **14. MOTHER'S MAIDEN NAME** Mary A. Wood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ☐ **16. SOCIAL SECURITY NO.** 12 Francis St **17. INFORMANT** Mrs James A. Walton Annapolis Md

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (e)
334X DUE TO Asphyxia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Aspiration
Cerebral arteriosclerosis with convulsive disorder 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
INTERVAL BETWEEN ONSET AND DEATH 15 minutes
20 minutes
5 years

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 **20d. INJURY OCCURRED** While at work ☐ Not While at work ☐ **20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) **20f. (City or town)** (County) (State)

21 I certify that (I) Richard I. Hochman attended the deceased from... 1/11... 1962 to 3/28... 1962, that (I) (we) last saw the deceased alive on 3/26 1962, and that death occurred at 7:00 PM, from the causes and on the date stated above.

22a. SIGNATURE Richard I. Hochman **22b. DATE SIGNED** 3/29/62
M.D. **ATTENDING PHYS.** ☒ **MED. DIRECTOR** ☐ **STAFF PHYS.** ☐

22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D. **22d. ADDRESS** 59 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial **23b. DATE THEREOF** Mar 30-62 **23c. NAME OF CEMETERY OR CREMATORY** St Marys Cent **23d. LOCATION** (City, town or county) (State) Annapolis Md

24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons **25a. REC'D BY REGISTRAR** Mar 30 '62 **25b. REGISTRAR'S SIGNATURE** William L. Thomas

TO FILL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7,61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02693
CERTIFICATE OF DEATH
02684

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>43 Bloomsbury Square</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> <u>BLANCHE</u> <u>FAUDREE</u> First Middle Last 4. DATE OF DEATH <u>March</u> <u>21</u> <u>19</u> <u>62</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 19, 1884</u> 9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>THOMAS JONES</u> 14. MOTHER'S MAIDEN NAME <u>IDA BANNING</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 16. SOCIAL SECURITY NO. <u>BOYD W. FAUDREE 811 SULPHUR SPRING RD. BALTO. MD.</u> 17. INFORMANT <u>BOYD W. FAUDREE 811 SULPHUR SPRING RD. BALTO. MD.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral thrombosis</u> <u>22</u> DUE TO <u>arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) <u>(deceased)</u> attended the deceased from <u>MARCH 17</u> , 19 <u>62</u> , to <u>MAR 21</u> , 19 <u>62</u> , that (I) <u>(w)</u> last saw the deceased alive on <u>MAR 21</u> , 19 <u>62</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>G. Church</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>G. CHURCH</u> 22d. ADDRESS <u>121 Cathedral St., Annapolis, Md.</u> 22b. DATE SIGNED <u>3/22/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>3-24-1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARGARETS CEM.</u> 23d. LOCATION (City, town or county) (State) <u>A.A. Co MD.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR, SON ANNAPOLIS MD.</u> ADDRESS 25a. REC'D BY REGISTRAR <u>MAR 27 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Pinner</u>	

TO BE FILLED BY THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

24 hours after death

Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

02694		02685	
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>1 yr.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>300 Maryland Ave.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> d. STREET ADDRESS <u>See 1 d.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Laura Virginia Finkenbinder</u>		4. DATE OF DEATH <u>March 12 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 23, 1889</u>
9. AGE (in years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hs w f.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>212-30-2167</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore City</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thos. A. Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Laura Isabelle Ray</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Dorothy Brigerman</u>	
17. INFORMANT <u>See 1.</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> + 222-1 DUE TO <u>Cerebral vascular hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Arterio sclerotic C.V. D.</u>			
PART II. OTHER SIGNIF. COND. CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Diabetes Mellitus, Osteoarthritis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>June 1962</u> to <u>Mar. 12, 1962</u> , that (I) <u>(see)</u> last saw the deceased alive on <u>Mar. 11, 1962</u> , and that death occurred <u>3:05 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>C. Earl Hill</u>			
22b. DATE SIGNED <u>12 Mar. 62</u>			
22c. PHYSICIAN'S NAME (Type) <u>C. EARL HILL M.D. 3708 Mountain Rd. Pasadena, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>15 March 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cems</u>		23d. LOCATION (City, town or county) (State) <u>Brooklyn PCD Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u> </u>	
ADDRESS <u>Glen Burnie, Md.</u>		DATE <u>MAR 13 '62</u>	



TO BE FILLED OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02686

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DEALE</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ST. MARY'S</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DEALE</u> d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>W</u> Middle <u>DONALD</u> Last <u>FORD</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>19</u> Year <u>1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-2-20-1908</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STATIONER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DEALE MD</u>	
11. BIRTHPLACE (Country & State or foreign country) <u>DEALE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Ford</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Rogers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218 14 3648</u>	
17. INFORMANT <u>Willard F. Smith</u>		Address <u>Shady Side, Md.</u>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4-2-20-1908</u> DUE TO <u>4-2-20-1908</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Immediate</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1961</u> to <u>March 19 1962</u> , that (I) (we) last saw the deceased alive on <u>March 18 1962</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Willard F. Smith</u>		22b. DATE SIGNED <u>3/19/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH</u>		22d. ADDRESS <u>Shady Side, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>2000 R</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Willard F. Smith</u>		25a. REC'D BY REGISTRAR <u>Mar 22 '62</u>	
ADDRESS <u>Shady Side, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO REGISTRAR: This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02696
CERTIFICATE OF DEATH
02687

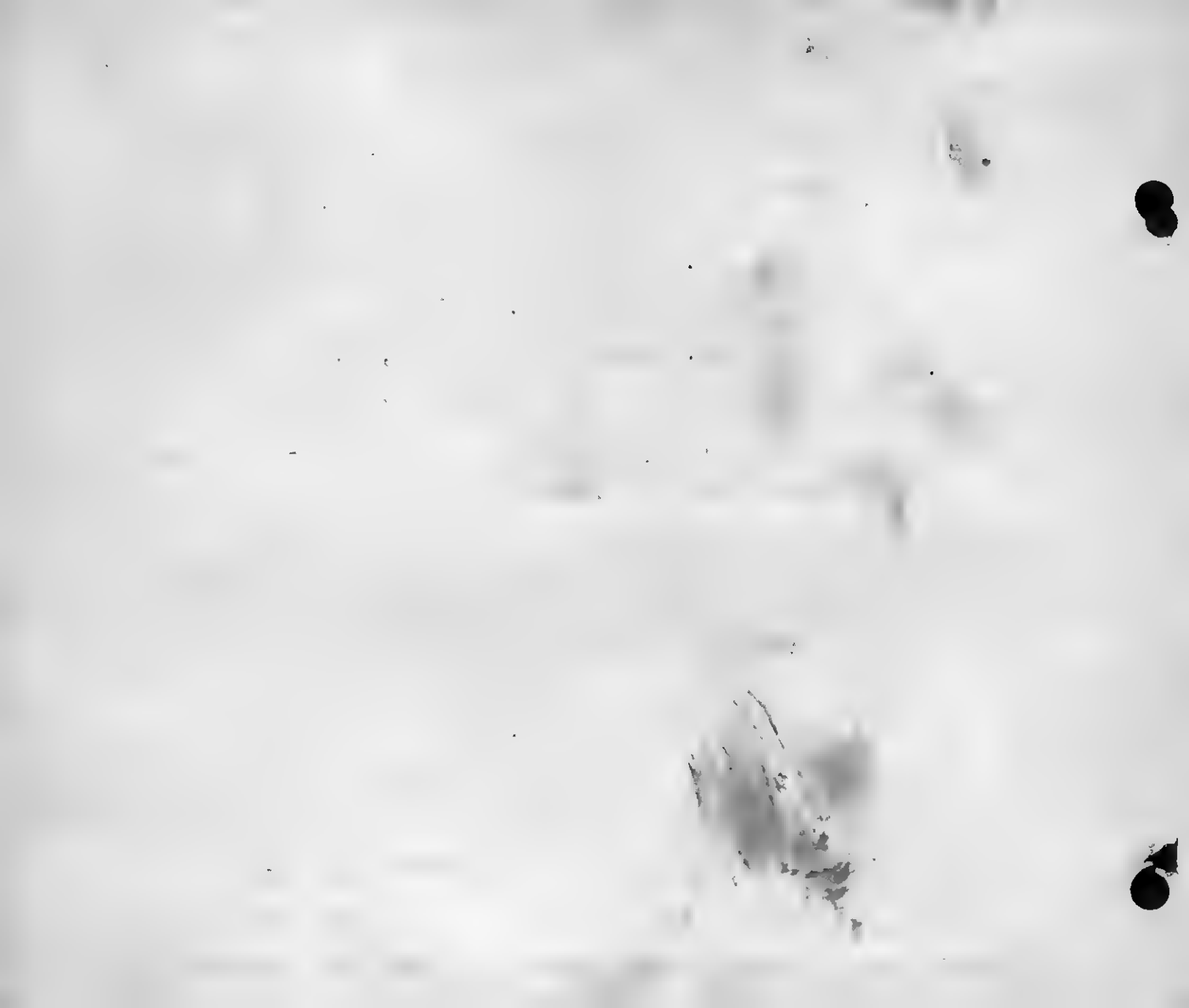
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bay Head</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md</u> b. COUNTY <u>aa</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bay Head</u> d. STREET ADDRESS <u>R.F.D. Annapolis</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mamie R. FULLERTON</u>		4. DATE OF DEATH Month Day Year <u>Mar 14th 1962</u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 12th 1898</u> 9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Frankford Rt. N.S.A</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>John R. Williams</u> 14. MOTHER'S MAIDEN NAME <u>Sarah Matthe Buckley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u> 17. INFORMANT Address <u>Mr Joseph W. Grimes</u> (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 32X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis, generalized</u> (a), stating the underlying cause last DUE TO (c) <u>Arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES</u> <u>10 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II or item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 1954</u> to <u>14 Mar, 1962</u> that (I) (we) last saw the deceased alive on <u>10 January 1962</u> and that death occurred at <u>301</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward S. Beck</u> 22c. PHYSICIAN'S NAME (Type) <u>Edward S. BECK, M.D.</u>		22b. DATE SIGNED ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>71 Franklin St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Mar 16th 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cem</u> 23d. LOCATION (City, town or county) (State) <u>Annapolis Md</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u> 25a. REC'D BY REGISTRAR <u>Mar 19 62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO BE FILLED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02697 CERTIFICATE OF DEATH 02688

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE Maryland f. COUNTY Anne Arundel g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis h. STREET ADDRESS 4 Stewart Ave. i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY M. GILDEN 4. DATE OF DEATH 3 20 1962		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Feb. 12, 1909 9. AGE (In years last birthday) 53 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice President 10b. KIND OF BUSINESS OR INDUSTRY Auto. Company 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md. 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Gilden 14. MOTHER'S MAIDEN NAME Sarah Land	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 213 22 1193 17. INFORMANT Mrs Sara I Gilden- Wife- same as # 2		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hodgkin's disease</u> 201X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>201X</u> DUE TO (c) <u>201X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Myocardial Infarction</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 4-12 gm.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug. 1957 to 3/20 1962 that (I) (we) last saw the deceased alive on 3/20 1962, and that death occurred 8:30 PM, from the causes and on the date stated above.		22a. SIGNATURE Richard A. Peeler M.D. 22b. DATE SIGNED March 20, 1962 22c. PHYSICIAN'S NAME (Type) Richard Peeler 22d. ADDRESS Annapolis, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF March 21, 1962 23c. NAME OF CEMETERY OR CREMATORY Kneseth Israel 23d. LOCATION (City, town or county) Annapolis, Maryland (State)		24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Maryland 25a. REC'D BY REGISTRAR MAR 23 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02688

CERTIFICATE OF DEATH

Reg. Dist. No.

02689

1. PLACE OF DEATH a. COUNTY <i>St. A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Ind.</i> b. COUNTY <i>St. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Frederick C. Simer</i>		4. DATE OF DEATH <i>Mar. 15 1962</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 31 1900</i>
9. AGE (In years last birthday) <i>61</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chauffeur</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Annapolis</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>John Simer</i>		14. MOTHER'S MAIDEN NAME <i>Theresa Cropp</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Katherine Simer</i>		Address <i>(wife)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO (b) <i>Cerebrovascular Accident</i> DUE TO (c) <i>Cardiac Failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 mos</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1-2-62</i> , 19, to <i>3-15-62</i> , 19, that I last saw the deceased alive on <i>3-15-62</i> , 19, and that death occurred at <i>5:45</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. T. Allen</i> M.D.		DATE SIGNED <i>3-16-62</i>	
PHYSICIAN'S NAME (Type) <i>A. T. ALLEN</i>		<i>Annapolis Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>Mar. 18 1962</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Fine Lawn</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. B. Johnson</i>		ADDRESS <i>Annapolis</i>	
24a. REC'D BY REGISTRAR <i>Charles S. Hanna</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Hanna</i>	
DATE <i>MAR 20 '62</i>			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02699

04091

1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN b 13 years 6 mos. 4 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS 1714 Etting Street			
3. NAME OF DECEASED (Type or print) Campbell				4. DATE OF DEATH Month 3 Day 30 Year 1962			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Divorced		8. DATE OF BIRTH 1881	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 3 Days 30		IF UNDER 24 HRS. Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Goode				14. MOTHER'S MAIDEN NAME Ellen Stovall			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 524 DUE TO Conditions, if any, which gave rise to immediate cause (b) Bronchiectasis (a), stating the underlying cause last. } DUE TO (c) -----						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Chronic Brain Syndrome Associated with Senile Brain Disease							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> el work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that (i) (this hospital) attended the deceased from 9/20 , 19 48 , to 3/30 , 19 62 , that (i) (we) last saw the deceased alive on 3/30 , 19 62 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Lionel McHenry Kapp, M.D.				22b. DATE SIGNED 3/30/62			
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Kapp, M.D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 4-6-62		23c. NAME OF CEMETERY OR CREMATORY U. of Md.		23d. LOCATION (City, town or county) (State) Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr. - Annap. Md.				25a. REC'D BY REGISTRAR APR 10 '62			
25b. REGISTRAR'S SIGNATURE William L. Thomas							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

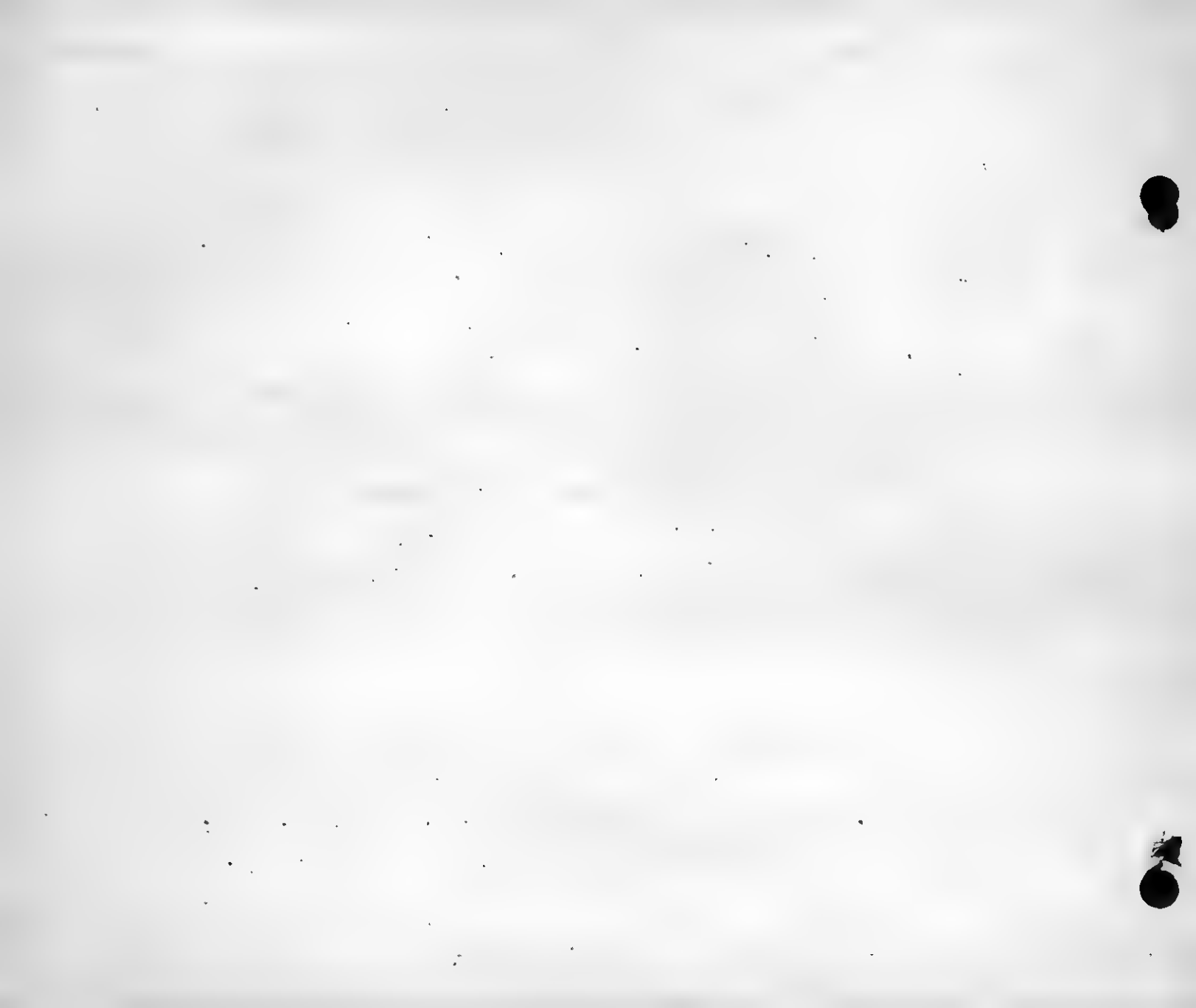
Item 9 Film G-508 2/13/62 iwk

02700

CERTIFICATE OF DEATH

Reg. Dist. No. 02690

1. PLACE OF DEATH a. COUNTY <u>A. Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A. Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Glen Burnie Md</u>	
c. LENGTH OF STAY IN 1b <u>20 yrs</u>		d. STREET ADDRESS <u>1108 Wilson Rd</u>	
e. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>VIRGINIA A. GREEN</u>		4. DATE OF DEATH <u>March 9 1962</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 16-1916</u>
9. AGE (In years last birthday) <u>46 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Copier Co</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Prints King</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Jones</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elwood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>272-16-4338</u>	
17. INFORMANT <u>Theo W Green</u>		Address <u>1108 Wilson Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic coma</u> DUE TO <u>Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Carcinoma of cervix</u> DUE TO (c) <u>Carcinoma of cervix</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov. 17, 1961</u> to <u>March 9, 1962</u> that I last saw the deceased alive on <u>March 8, 1962</u> , and that death occurred at <u>5:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edmond I. Moushabek</u> M.D.		ADDRESS (Street, city or town, state) <u>21015 Ritchie Highway</u>	
DATE SIGNED <u>3/9/62</u>			
PHYSICIAN'S NAME (Type) <u>EDMOND I. MOUSHABEK</u> <u>Glen Burnie, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>March 12-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Weston Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Wash Bluff (at) Dorsey Rd Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A Fink</u>		ADDRESS <u>Glen Burnie Md</u>	
24a. REC'D BY REGISTRAR <u>WALK 12-62</u>		24b. REGISTRAR'S SIGNATURE <u>Conrad S. Thomas</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

C2701

CERTIFICATE OF DEATH

02691

Item 7 Film G309 3/11/62

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL - Annapolis</u> d. STREET ADDRESS <u>RFD - Epping Forest</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>ETHEL</u> Last <u>GUNTER</u>		4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1962</u>		5. SEX <u>Female</u>							
6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 6, 1900</u>							
9. AGE (In years last birthday) <u>61</u> yrs <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Nurse</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Missouri</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months	Days										
	Hours										
	Min										
13. FATHER'S NAME <u>John Edwin McPherson</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Vermilion</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>-</u> 16. SOCIAL SECURITY NO. <u>-</u> 17. INFORMANT <u>Rolla P. McPherson</u> Address <u>(2)</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO (b) <u>ARTERIOSCLEROSIS, GENERALIZED</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 HOURS</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u> 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>-</u> p.m. <u>-</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u> 20f. (City or town) (County) (State) <u>-</u>											
21. I certify that (I) (the doctor) attended the deceased from <u>1 FEB</u> <u>1962</u> to <u>Mar. 13,</u> <u>1962</u> , that (I) (the doctor) last saw the deceased alive on <u>Mar. 13,</u> <u>1962</u> , and that death occurred at <u>9:10 AM</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Edward S. Beck</u> 22b. DATE SIGNED <u>9:10 AM</u> 22c. PHYSICIAN'S NAME (Type) <u>Edward S. Beck, M.D.</u> 22d. ADDRESS <u>71 Franklin St., Annapolis, Md.</u>											
23a. BURIAL, CREMATION <u>Burial</u> 23b. DATE THEREOF <u>3-17-1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Memorial</u> 23d. LOCATION (City, town or county) (State) <u>Annapolis Md.</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> ADDRESS <u>Sons Annapolis Md.</u> 25a. REC'D BY REGISTRAR <u>DATE MAR 19 '62</u> 25b. REGISTRAR'S SIGNATURE <u>-</u>											

MEDICAL CERTIFICATION

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

1
FOR STATE
HEALTH DEPT.

TO CITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other action is necessary, Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02702

02693

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Severn		c. LENGTH OF STAY IN 1b 6 months		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Same		b. COUNTY Same		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same		d. STREET ADDRESS Same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Route 1 Box 319 Russell Harwood		4. DATE OF DEATH March 4th. 1962 19		5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/27/05		9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frank Harwood		14. MOTHER'S MAIDEN NAME Barbara Winter		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 11 War.		16. SOCIAL SECURITY NO. 214-24-6474		17. INFORMANT Mrs. Nadine Harwood (Wife)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
INTERVAL BETWEEN ONSET AND DEATH Sudden																	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.																	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19																	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>																	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)																	
20f. (City or town) (County) (State)																	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
CHIEF MEDICAL EXAMINER <input type="checkbox"/>																	
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																	
DATE SIGNED 3/4/62																	
Address (Street, city, town, or county) Glen Burnie, Md.																	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial																	
22b. DATE THEREOF 6th March 1962																	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l. Cem.																	
22d. LOCATION (City, town, or country) (State) Baltimore, Maryland																	
23. FUNERAL DIRECTOR Richard V. Singleton																	
ADDRESS Glen Burnie, Md.																	
24a. REC'D BY REGISTRAR 7 '62																	
24b. REGISTRAR'S SIGNATURE Richard V. Singleton																	

TO BE FILLED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02703

Item 7 Film G-08

CERTIFICATE OF DEATH

02694

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN It <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>815 West St.</u>	
3. NAME OF DECEASED (Type or print) <u>Charles H. HEROLD</u>		4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 4, 1877</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>4</u> Hours <u>1</u> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick Masonary</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Contracting Pct</u>	
13. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. FATHER'S NAME <u>George Herold</u>		16. MOTHER'S MAIDEN NAME <u>Unknown</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		18. SOCIAL SECURITY NO. <u>Clarence E. Williams</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Pulmonary metastases</u> DUE TO (b) <u>Carcinoma of prostate</u> DUE TO (c) <u></u>		20. INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u> <u>4 years</u>	
21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <u></u>			
22. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
24a. TIME OF INJURY Month, Day, Year <u>Dec. 24, 1961</u> Hour <u>6:30 PM</u> m. <u>PM</u>		24b. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
24c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		24d. (City or town) <u>Annapolis</u> (County) <u>Md</u> (State) <u>Md</u>	
25. I certify that (I) <u>Richard I. Hochman</u> attended the deceased from <u>Dec. 24, 1961</u> to <u>Mar. 5, 1962</u> that (I) <u>Richard I. Hochman</u> saw the deceased alive on <u>Mar. 5, 1962</u> and that death occurred at <u>6:30 PM</u> from the causes and on the date stated above.			
26a. SIGNATURE <u>Richard I. Hochman</u>		26b. DATE SIGNED <u>3/6/62</u>	
27a. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, M.D.</u>		27b. ADDRESS <u>59 Franklin St., Annapolis, Md.</u>	
28a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		28b. DATE THEREOF <u>3-7-1962</u>	
28c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>		28d. LOCATION (City, town or county) <u>Annapolis</u> (State) <u>Md</u>	
29. FUNERAL DIRECTOR'S SIGNATURE <u>Julian M. Taylor Sr</u>		30. ADDRESS <u>Annapolis Md</u>	
31. REC'D BY REGISTRAR <u>WAR 9 '62</u>		32. REGISTRAR'S SIGNATURE <u>William L. Thomas</u>	

FOR STATE
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C2704

02695

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Severn c. LENGTH OF STAY IN 1b Few instants. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route 3		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY A.A. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Millersville d. STREET ADDRESS Box 163 Route 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kimberly Joe Holmes		4. DATE OF DEATH Month Day Year March 12th. 1962			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1961		9. AGE (In years last birthday) Months Days 7		10. FUND 1 YEAR IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John J. Holmes		14. MOTHER'S MAIDEN NAME Peggy Jean Buxtanger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address John J. Holmes (father)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fracture of skull Conditions, if any, which gave rise to immediate cause (b) 16X (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sudden					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile in which she was riding hit the rear of a truck.			
20c. TIME OF INJURY Month, Day, Year 10.15 A.M. 3/12/62		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 3	
20f. (City or town) Severn		20g. (County) A.A.		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Gustave H. Faubert		M.D. Gustave H. Faubert, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/16/62		22c. NAME OF CEMETERY OR CREMATORY St. Marys	
22d. LOCATION (City, town, or country) Cincinnati, Ohio		22e. ADDRESS Hopping and Kirkley, Glen Burnie, Md.		22f. DATE MAR 16 '62	
24a. REC'D BY REGISTRAR Arthur S. Kraus		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1172

FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
C2705 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02696

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn		c. LENGTH OF STAY IN 1b Few instants		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 3		First		Last		4. DATE OF DEATH Month Day Year March 12th. 19 62	
3. NAME OF DECEASED (Type or print) Peggy Jean Holmes		Middle		5. SEX F		6. COLOR OR RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 5/20/36		9. AGE (In years last birthday) 25yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Burtanger		14. MOTHER'S MAIDEN NAME Esther Tirscher		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT P.F.C John J. Holmes (husband)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 816 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Fracture of skull DUE TO (c) Multiple lacerations		INTERVAL BETWEEN ONSET AND DEATH Sudden Sudden		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Automobile in which she was riding hit the rear of a truck.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year 10.15 A.M. 3/12/62		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 3		20f. (City or town) Severn		20g. (County) A.A.		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <i>Gustave H. Faubert</i>		DATE SIGNED 3/12/62		EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		Address (Street, city, town, or county) Glen Burnie, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/16/62		22c. NAME OF CEMETERY OR CREMATORY St. Marys		22d. LOCATION (City, town, or country) (State) Cincinnati, Ohio	
23. FUNERAL DIRECTOR Hopping and Kirkley, Glen Burnie, Md.		24a. REC'D BY REGISTRAR MAR 16 '62		24b. REGISTRAR'S SIGNATURE <i>William L. Hanna</i>			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02706

02697

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>1 mo. 23 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>12 North Caroline St.</u> e. LAST OF DEATH <u>Johns</u>			
3. NAME OF DECEASED (Type or print) <u>Hattie</u>		4. DATE OF DEATH <u>3</u> <u>23</u> <u>1962</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1904</u>	9. AGE (In years last birthday) <u>57</u> yrs.	10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Unknown</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO <u>Bed Sores</u> Conditions, if any, which gave rise to immediate cause (b) <u>-----</u> (c) <u>Late Syphilis and Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>					
20c. TIME OF INJURY Month. Day Year Hour a.m. ----- p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>			
20f. (City or town) <u>1/30</u>		20g. (County) <u>1962</u>		20h. (State) <u>5/23</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>1/30</u> <u>1962</u> <u>to</u> <u>5/23</u> <u>1962</u> <u>that (I) (we) last saw the deceased alive on</u> <u>3/23</u> <u>1962</u> <u>and that death occurred at</u> <u>228</u> <u>M.</u> <u>from the causes and on the date stated above.</u>							
22a. SIGNATURE <u>L. BENEFIT M.D.</u>		22b. DATE SIGNED <u>3/23/62</u>		22c. PHYSICIAN'S NAME (Type) <u>L. BENEFIT M.D.</u>			
22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>		22e. REC'D BY REGISTRAR <u>-----</u> 22f. REGISTRAR'S SIGNATURE <u>-----</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Funeral</u>		23b. DATE THEREOF <u>3/26/62</u>		23c. NAME OF CEMETERY OR CREMATOR <u>Brooklyn Md.</u>			
23d. LOCATION (City, town or county) <u>Brooklyn Md.</u>		23e. NAME OF REMOVAL OR CREMATOR <u>-----</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>E.O. Wilson</u>		24a. ADDRESS <u>1000 Brantley Ave.</u>		24b. DATE <u>MAR 27 1962</u>			

MEDICAL CERTIFICATION

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02698

1. PLACE OF DEATH o COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>16</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>9 Wilson Road</u>				d. STREET ADDRESS <u>9 Wilson Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>7</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>3-</u> Day <u>11</u> Year <u>1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 25-1877</u>	
9. AGE (In years last birthday) <u>84</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mason Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brick Layer</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Marion Jones</u>		14. MOTHER'S MAIDEN NAME <u>Susan Frazer</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or date of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs Andrew H. Brown</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Pancreas</u> DUE TO (b) <u>15 7X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>12/29/1961</u> to <u>3/11/1962</u> that (I) (we) last saw the deceased alive on <u>3/9/1962</u> and that death occurred at <u>1:15</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard I. Hochman</u>				22b. ADDRESS <u>59 Franklin St., Annapolis, Md.</u>		22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>2-16-1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sins</u>				25a. REC'D BY REGISTRAR <u>—</u>		25b. REGISTRAR'S SIGNATURE <u>—</u>	

TO HO... OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.



02708

CERTIFICATE OF DEATH

02699

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena d. STREET ADDRESS Box 278 R.F.D. #2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Helen E. Jones		4. DATE OF DEATH Month March Day 10 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/19/08
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 54
11. BIRTHPLACE (County & State, or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Apical Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity		INTERVAL BETWEEN ONSET AND DEATH 5 days 1 1/2 y.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m., p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-8-62 to 3-10-62 that (I) (we) last saw the deceased alive on 3-10-62 and that death occurred at 11 M, from the causes and on the date stated above.			
22a. SIGNATURE Frank M. Shipley		22b. DATE SIGNED 3-12-62	
22c. PHYSICIAN'S NAME (Type) Dr. Frank Shipley		22d. ADDRESS Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/13/62	23c. NAME OF CEMETERY OR CREMATORY Cadowridge Memorial Cemetery Balto Md.	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE McCully 130 E Fort Ave Balto 30 Md.		25a. REC'D BY REGISTRAR APR 2 '62	
		25b. REGISTRAR'S SIGNATURE Conrad L. Frank	

TO ALL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO TOTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02709 CERTIFICATE OF DEATH 02700

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: R e. STATE Maryland b. COUNTY St. Louis	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY (in days) 4 yrs. 11 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 405 Forrest Street	
3. NAME OF DECEASED (Type or print) Lee		4. DATE OF DEATH Month 3 Day 7 Year 1962	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1912
9. AGE (In years last birthday) 49 yrs		10. IF UNDER 1 YEAR Months 7 Days 1	
11. IF UNDER 24 HRS. Hours 1 Min. 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Jones		14. MOTHER'S M.A.DEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO 229-46-0753	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) 11-9-62 (c) Old Skull Fracture with Brain Injury DUE TO (e), stating the underlying cause last (c) (Many yrs. ago)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old Skull Fracture with Brain Injury		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Old Skull Fracture with Brain Injury	
20c. TIME OF INJURY Hour a.m. 19 Month, Day, Year p.m. 3/7		20d. INJURY OCCURRED While at work <input type="checkbox"/> While not at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Balt. Md.	
21. I certify that (I) (th's hospital) attended the deceased from 6/21 19 56 to 3/7 19 62 , that (I) (we) last saw the deceased alive on 3/7 19 62 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Hildegard Heard Reissman		22b. DATE 3/8/62	
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M.D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 3-9-62	
23c. NAME OF FUNERAL HOME Univ. of Md. Hosp.		23d. LOCATION (City, town or county) (State) Balt. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Feece		25. REC'D BY REGISTRAR MAR 14 '62	
25b. REGISTRAR'S SIGNATURE Annapolis, Md.		25c. REGISTRAR'S SIGNATURE Wm. E. Moore	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
02710					MEDICAL EXAMINER'S CERTIFICATE OF DEATH					02701				
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus Arbutus			d. STREET ADDRESS Ashbourne Ashhaven Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital					d. STREET ADDRESS									
3. NAME OF DECEASED (Type or print) William FRANCIS KENNEDY					4. DATE OF DEATH Month Day Year March 25 1962									
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 9, 1927		9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor				10b. KIND OF BUSINESS OR INDUSTRY Social Security		11. BIRTHPLACE (State or foreign country) Balto. Md.				12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME Charles Kennedy					14. MOTHER'S MAIDEN NAME Edith Englehoff									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes World War II					16. SOCIAL SECURITY NO. 218-22-8304		17. INFORMANT 5574 Ashbourne Rd. (27) Mrs. Genevieve L. Kennedy							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to drowning 8 50 X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Fishing from boat which capsized, fell overboard									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. March 25, 1962			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chesapeake Bay			20f. (City or town) Anne Arundel Co., Md.		(County)		(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>Peter W. Rieckert</i>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED March 26, 1962				
EXAMINER'S NAME (Type) Peter W. Rieckert, M.D.					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>									
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
					Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 28, 1962		22c. NAME OF CEMETERY OR CREMATORY Balto. Nat. Cem.			22d. LOCATION (City, town, or country) Balto. Md.			(State)				
23. FUNERAL DIRECTOR G. TANNAN Schwab					ADDRESS					24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
										DATE MAR 28 '62				



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FOR STATE
HEALTH DEPT.

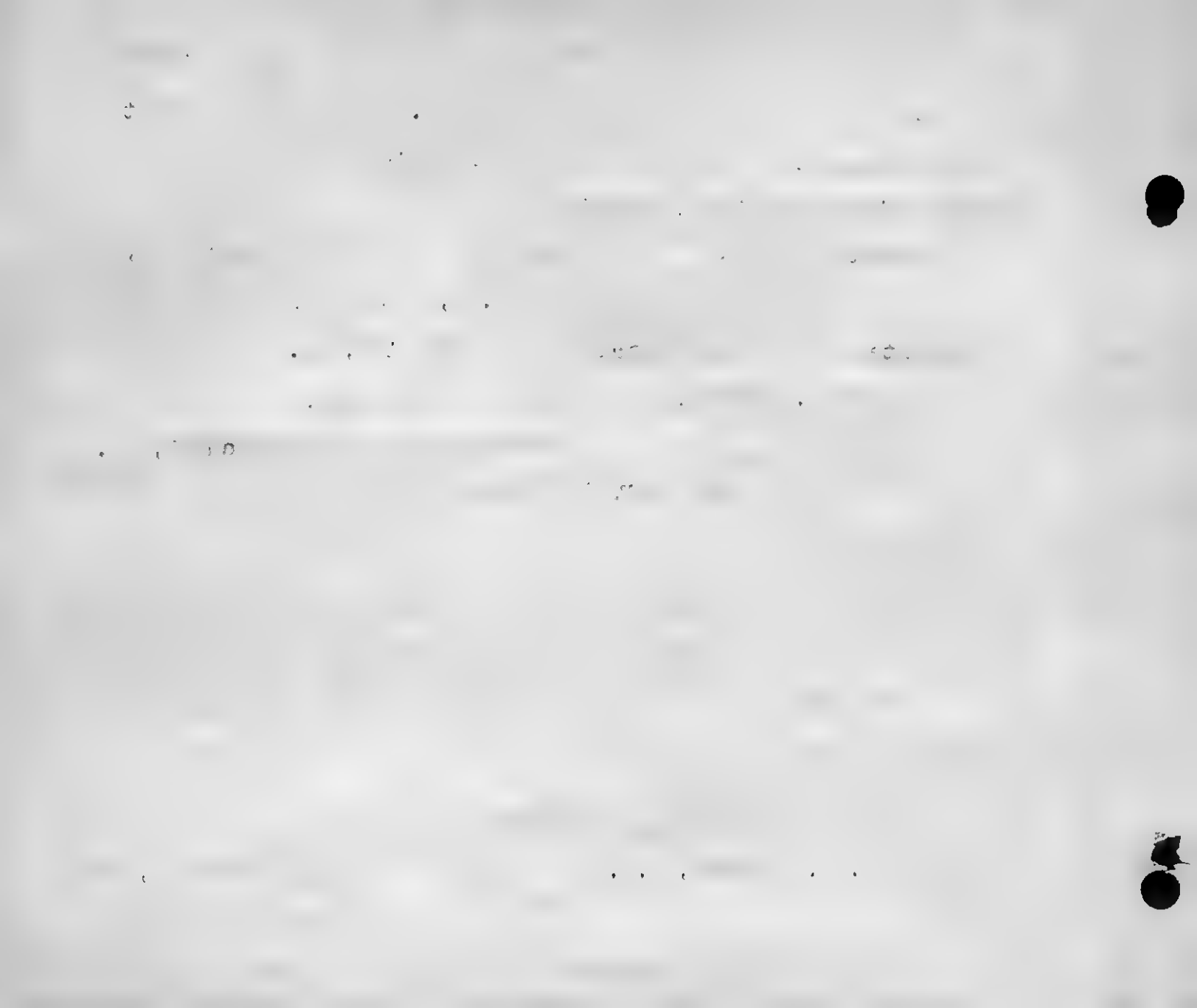
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02711 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02702

1. PLACE OF DEATH a. COUNTY AA		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Talbot	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Red House Cove		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) McDaniels	
c. LENGTH OF STAY IN 1b 20x-2		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Nagothy River off Gibson Island		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert Preston		4. DATE OF DEATH Month March Day 21 Year 1962	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 23, 1901
9. AGE (In years last birthday) 61	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	11. BIRTHPLACE (State or foreign country) Neavitt, Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George H. Lambdin	14. MOTHER'S MAIDEN NAME Nora Ball	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Catherine Lambdin, MacDaniel, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE G. H. Faubert, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) G. H. Faubert, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-24-62	
22c. NAME OF CEMETERY OR CREMATORY Wright Cemetery		22d. LOCATION (City, town, or country) (State) St. Michaels, Md.	
23. FUNERAL DIRECTOR Hampton Harrison		24a. REC'D BY REGISTRAR Mar 27 '62	
ADDRESS St. Michaels		24b. REGISTRAR'S SIGNATURE Charles E. Thane	

MEDICAL CERTIFICATION



1
M
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MEDICAL CERTIFICATION
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VR A15 (4)
15M 7/61

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M
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1
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND
02712
02705
MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 635 Chase St.	
3. NAME OF DECEASED (Type or print) Nannie		4. DATE OF DEATH March 28 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 25, 1882	
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	
11. IF UNDER 24 HRS. Hours 0 Mins. 0		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME MORGAN M. WAYSON		14. MOTHER'S MAIDEN NAME SARAH A. BERCKHEAD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT MRS. THEODORE YOST		18. ADDRESS ANNAPOLIS MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric Thrombosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 1 week 10-15 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) Richard I. Hochman attended the deceased from Mar. 26, 1962 to Mar. 28, 1962 , that (I) yes last saw the deceased alive on Mar. 28, 1962 , and that death occurred at 4:30 PM from the causes and on the date stated above.		22b. DATE SIGNED 3/29/62	
22a. SIGNATURE Richard I. Hochman		22c. ADDRESS 59 Franklin St., Annapolis, Md.	
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.		22d. ADDRESS 59 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-31-1962	
23c. NAME OF CEMETERY OR CREMATORY ST. MARGARETS CEM.		23d. LOCATION (City, town or county) (State) AA. CO MD.	
24. FUNERAL DIRECTOR'S SIGNATURE JOHN M. TAYLOR SONS		25a. REC'D BY REGISTRAR DATE MAR 30 '62	
25b. REGISTRAR'S SIGNATURE Charles L. Kraus		25c. REGISTRAR'S SIGNATURE Charles L. Kraus	

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 22 Film G310 4/2/62 mh

02713

CERTIFICATE OF DEATH

Reg. Dist. No. 02705

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>		c. LENGTH OF STAY IN 1b <u>1 yr</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade, Md.</u>		d. STREET ADDRESS <u>Qtrs #7330-B Kelley Loop</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kimbrough Army Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marilyn</u> Middle <u>P</u> Last <u>Lowe</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>18</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 March 1938</u>
9. AGE (In years last birthday) <u>24 yrs.</u>		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hugh Bittner</u>		14. MOTHER'S MAIDEN NAME <u>Kathryn Rainesberger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Husband</u>		Address <u>Qtrs 7330-B Ft Geo G. Meade, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral lacerations</u> <u>8 25 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>DOA</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Automobile accident</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>6:45 p.m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Reece MacArthur</u>		20f. (City or town) (County) (State) <u>Ft Geo G. Meade, AA Md</u>	
21. I certify that I attended the deceased from <u>18 March 1962</u> to <u>18 March 1962</u> , and that death occurred at <u>7:10 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Kimbrough AH Ft G.G. Meade, Md 18 Mar 62</u>	
ACTUAL SIGNATURE <u>Marvin M. Nachlas</u>		PHYSICIAN'S NAME (Type) <u>MARVIN M. NACHLAS, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 23, 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Port Angeles</u>		22d. LOCATION (City, town, or county) (State) <u>Washington</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lancel Funeral Home Inc.</u>		ADDRESS <u>550 North 1st St</u>	
24a. REC'D BY REGISTRAR <u>MAR 23 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

1
FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22 Film G310 4/2/62 mh

02714

CERTIFICATE OF DEATH

02706
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Fort George G. Meade</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>	
c. LENGTH OF STAY IN 1b <u>1 yr</u>		d. STREET ADDRESS <u>Qtrs # 7330-B</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KIMBROUGH ARMY HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SALLI</u> Middle <u>J</u> Last <u>LOWE</u>		4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>19 62</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7 December 1957</u>
9. AGE (In years lost birthday) <u>4</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>Washington</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Thomas Lowe</u>	
14. MOTHER'S MAIDEN NAME <u>Marilyn P Bittner</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service) <u>-</u>	
16. SOCIAL SECURITY NO <u>-</u>		INFORMANT Address <u>Father - Qtrs # 7330-B Ft Geo G. Meade, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral lacerations</u> <u>8 25 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>DOA</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Auto accident</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>6:45</u> a. m. <u>Pp. m.</u> <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Reece & MacArthur</u>		20f. (City or town) (County) (State) <u>Ft G G Meade, AA Md.</u>	
21. I certify that <u>examined</u> <u>18</u> <u>Mar</u> <u>1962</u> <u>7:10 P</u> <u>M</u> , from the causes and on the date stated above. <u>pronounced dead</u> <u>and that death occurred at</u> <u>7:10 P</u> <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Marvin M Nachlas</u> M.D.		DATE SIGNED <u>18 Mar 62</u>	
PHYSICIAN'S NAME (Type) <u>MARVIN M. NACHLAS, M.D.</u>		ADDRESS (Street, city or town, state) <u>Kimbrough AH Ft G. G. Meade, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 23, 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>550 WASH BLVD</u>		22d. LOCATION (City, town, or county) (State) <u>Port Angeles WASH.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LAUREL FUNERAL HOME INC</u>		24b. REGISTRAR'S SIGNATURE <u>Claring P. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02715

02707

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Md. b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, M	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 518 Grain Highway N		e. STREET ADDRESS 518 Ctain Highway N	
3. NAME OF DECEASED (Type or print) First Lucy Middle May Last Marsteller		4. DATE OF DEATH Month March Day 14 Year 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 17, 1885
9. AGE (In years last birthday) yrs 76		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Frederick, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Stitely		14. MOTHER'S MAIDEN NAME Sarah ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Thomas O. Marsteller, same as 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertensive Cardio-Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Disease (c) Disease		INTERVAL BETWEEN ONSET AND DEATH 72 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1955 to March 1962 that (I) (we) last saw the deceased alive on 3-14-1962 and that death occurred at 12 M , from the causes and on the date stated above.			
22a. SIGNATURE Charles R. MacDonald M.D.		22b. DATE SIGNED 3-16-62	
22c. PHYSICIAN'S NAME (Type) C. R. MacDonald, M.D.		22d. ADDRESS 204 Grain Highway SE, Glen Burnie	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/17/62	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City town, or county) (State) Baltimore 25, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley		25. REGISTRAR'S SIGNATURE W. L. E. K. and	
25a. REC'D BY REGISTRAR DATE MAR 20 '62		25b. REGISTRAR'S SIGNATURE	

TO INITIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02716

CERTIFICATE OF DEATH

02709

Item 14 Film G310 1/5/62 - mh

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route 10			d. STREET ADDRESS Route 10		
3. NAME OF DECEASED (Type or print) Margaret Elizabeth McCarthy			4. DATE OF DEATH March 26, 1962		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26, 1915		9. AGE (In years last birthday) 46 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Edward Leimbach		14. MOTHER'S MAIDEN NAME Margaret Unknown		12. CITIZEN OF WHAT COUNTRY? U. S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-05-8428		17. INFORMANT Mr. John J. McCarthy Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute pulmonary edema 1 + 2 0 DUE TO (b) Coronary arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) None					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from July 2, 1950 to March 26, 1962 ; that (I) (we) last saw the deceased alive on Mar. 21, 1962 , and that death occurred at 5 A.M. , from the causes and on the date stated above.					
22a. SIGNATURE R. M. McLaughlin M. D.					
22b. DATE SIGNED 3/26/62					
22c. PHYSICIAN'S NAME (Type) R. M. McLaughlin					
22d. ADDRESS 3708 Mountain Rd. Pasadena, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 30, 1962		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	
23d. LOCATION (City, town or county) Baltimore, Maryland		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE George J. Gonce		ADDRESS 4001 Ritchie Hwy. (25)		25a. REC'D BY REGISTRAR DATE MAR 30 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hinkle					

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02717		02710	
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Linthicum Heights</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address of institution) <u>Plaza Manor Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>McCubbin</u> Middle <u>Mac</u> Last <u>Cubbin</u>		4. DATE OF DEATH <u>March</u> <u>4</u> <u>1962</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 8</u> <u>1869</u> <u>92</u> yrs.
9. AGE (In years last birthday) <u>92</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Street Cleaner</u>	11. BIRTH PLACE (State or foreign country) <u>Baltimore</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Street Cleaner</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William J. McCubbin</u>		14. MOTHER'S MAIDEN NAME <u>Mary Macalister</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>NO</u>	
17. INFORMANT <u>Catherine Wise</u> Address <u>435 W. Greenwood Rd.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration and Inanition</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Malnutrition</u>			
(c) <u>Senility</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome due to Cerebral and Generalized</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Arteriosclerosis</u>	
20c. TIME OF INJURY Hour <u>19</u> a.m. <u>7/18/58</u> Month <u>3</u> Day <u>4</u> Year <u>1962</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/18/58</u> to <u>3/4/62</u> that (I) (we) last saw the deceased alive on <u>3/3/62</u> and that death occurred at <u>1 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Lionel M. Henry Mapp</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Lionel M. Henry Mapp, M.D.</u>		22d. ADDRESS <u>20 Deak Street, Annapolis Md.</u>	
23a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3-7-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Immanuel Lutheran Cemetery,</u>	23d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
24. FUNERAL DIRECTOR'S NAME <u>WILLIAM COOK, INC., 1217 ST. PAUL STREET, CITY 2</u>		25a. REC'D BY REGISTRAR <u>WMA</u> 3 '62	
25b. REGISTRAR'S SIGNATURE <u>C. L. H. H. H.</u>			

TO LOCAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02718

Item 9 Rm G308

3/14/62 iwk

02711

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN b <u>22 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne A undel General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL - Annapolis</u> d. STREET ADDRESS <u>Rt-4, Box-85</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>MC GHEE</u> Last <u>MC GHEE</u> 4. DATE OF DEATH <u>March 4 1962</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 1, 1883</u> 9. AGE (In years, last birthday) <u>78</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (County & State or foreign country) <u>Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Julus White</u> 14. MOTHER'S MAIDEN NAME <u>Dollie (MN unknown)</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Dollie Mc Ghee</u> Address <u>2442 K Street, N. W. - Daughter</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>brain hemorrhage due to</u> <u>hypertension</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>22 days</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) <u>(physician)</u> attended the deceased from <u>11 - 29</u> , 19 <u>61</u> , to <u>Mar. 4</u> , 19 <u>62</u> , that (I) <u>last</u> saw the deceased alive on <u>Mar 4</u> , 19 <u>62</u> , and that death occurred at <u>10:22 PM</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>Edith Rodler</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>10:22 PM</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edith Rodler, M.D.</u>		22d. ADDRESS <u>45 Franklin St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-10-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Danville, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edmund G. Gellman</u>		25a. REC'D BY REGISTRAR <u>9 '62</u> 25b. REGISTRAR'S SIGNATURE <u>William E. Kraus</u>	



CERTIFICATE OF DEATH

02712
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOS. ITAL, ANNAPOLIS, MD				1 d STREET ADDRESS 171 KING GEORGE STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALEXANDER Middle CECIL Last MORRIS				4. DATE OF DEATH Month MARCH Day 3 Year 1962			
5 SEX MALE	6 COLOR OR RACE CAUC	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 21 JAN 1889		9 AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. NAVY BAND LEADER			10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY		11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME DANIEL (n) MORRIS				14. MOTHER'S MAIDEN NAME HENRITTA (n) DONOVAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT ROSE O. MORRIS		Address 171 KING GEORGE STREET ANNAPOLIS, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANOXIA 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) UREMIA, EPHYSEMA P01274 DUE TO (c) CIRRHOSIS							INTERVAL BETWEEN ONSET AND DEATH 0700-1310
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB 26 , 1962, to MARCH 3 , 1962, that I last saw the deceased alive on MARCH 3 , 1962, and that death occurred at 1:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Naval Hospit Annapolis DATE SIGNED 3-3-62							
ACTUAL SIGNATURE Stephen B. Hiltabone, M.D.				PHYSICIAN'S NAME (Type) STEPHEN B. HILTABONE			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial				22b. DATE THEREOF 3-6-1962		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) (State) Washington D.C.				22e. LOCATION (City, town, or county) (State) Washington D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE John M. Scarpus				ADDRESS Annapolis MD		24a. REC'D BY REGISTRAR DATE 7 '62	
24b. REGISTRAR'S SIGNATURE J. L. S. Thomas							

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO THE MEDICAL EXAMINER: This certificate should be executed within 14 hours after death. If any doubt is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

1
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY A. A. Co.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis Glen Burnie	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Box 599 Mergate Drive	
3. NAME OF DECEASED (Type or print) CHARLES NEUBECK		4. DATE OF DEATH March 25 1962	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1902
9. AGE (In years last birthday) 60		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitorial		10b. KIND OF BUSINESS OR INDUSTRY Dept. of Education	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Frank Neubeck		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-7857	
17. INFORMANT Mrs. Marion Neubeck		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries with fractures of ribs, pelvic bones and diaphragmatic hernia 912.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by falling wall	
20c. TIME OF INJURY Month, Day, Year Hour 2:30 p.m. 3/25 1962		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Magothy Manor		20f. (City or town) Anne Arundel Co. (County) Maryland (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Peter W. Rieckert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Peter W. Rieckert, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED March 26, 1962	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/29/62	
22c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		22d. LOCATION (City, town, or country) Glen Burnie, Maryland (State)	
23. FUNERAL DIRECTOR George J. Gonce		ADDRESS 4001 Ritchie Hwy.	
24a. REC'D BY REGISTRAR DATE MAR 30 '62		24b. REGISTRAR'S SIGNATURE	

George J. Gonce

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02721

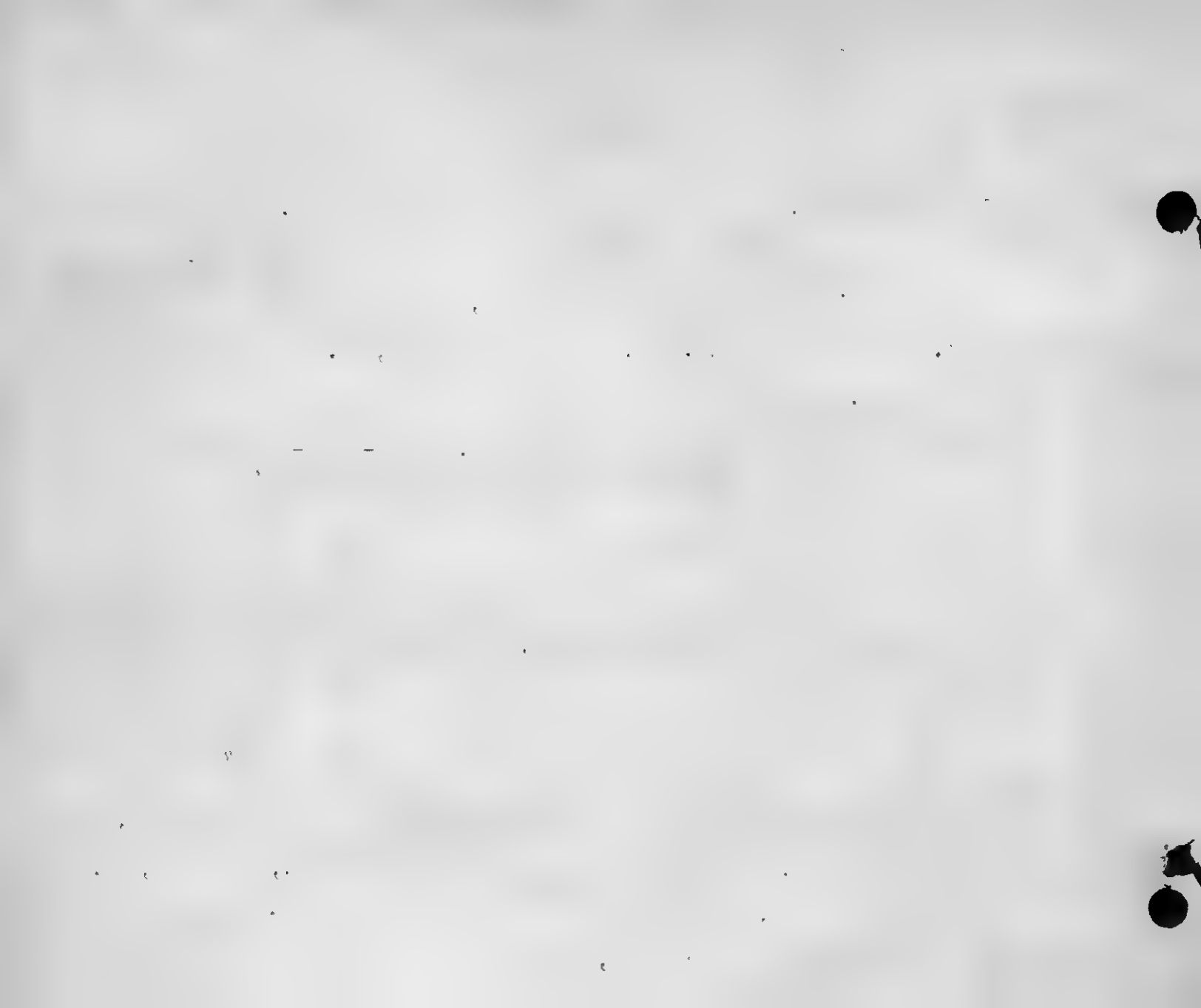
02714

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY in b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>114 Archwood Ave.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> d. STREET ADDRESS <u>114 Archwood Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CLARENCE O. NEWTON</u>		4. DATE OF DEATH <u>March 11, 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4, 1896</u>
9. AGE (in years last birthday) <u>65 yrs.</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Mins. <u> </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>	
11c. PLACE OF BIRTH (County & State, or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John H. Newton</u>		14. MOTHER'S MAIDEN NAME <u>Molly Basil</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mr John T. Newton - son - same as # 2</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute dilatation of the heart</u> <u>Sum death</u> 1. <u> </u> + <u> </u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>3/11/62</u> to <u>3/11/62</u> , that (I) (we) last saw the deceased alive on <u> </u> 19 <u> </u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Albert L. Anderson</u>		22b. DATE SIGNED <u>March 11, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Albert L. Anderson MD</u>		22d. ADDRESS <u>Southgate Ave., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 14, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Annapolis, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u> </u>	
ADDRESS <u>Annapolis, Maryland</u>		DATE <u>MAR 15 '62</u>	

MEDICAL CERTIFICATION

TO FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02722

02715

1. PLACE OF DEATH a. COUNTY <u>AA Co</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Deale</u> c. LENGTH OF STAY IN life <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA Co</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Deale, Md</u> d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARION FENNIMORE NUTWELL</u>		4. DATE OF DEATH Month Day Year <u>Mar 22 1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 14 1889</u>
9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>NUTWELL Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MARION Nutwell</u>		14. MOTHER'S MAIDEN NAME <u>ROSA Minnick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>J. BUNYAN NUTWELL</u>		Address <u>Deale, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/1</u> 19 , to <u>3/24</u> 19 , that (I) (we) last saw the deceased alive on <u>3/19</u> 19 , and that death occurred at <u>3:4</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Willard F. Smith</u>		22b. DATE SIGNED <u>3/24/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH, MD</u>		22d. ADDRESS <u>Willard F. Smith Shady Side Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3-24-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sherbert Cem</u>	23d. LOCATION (City, town or county) (State) <u>Deale, Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>T A Hardesty + Son</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 27 '62</u>	25b. REGISTRAR'S SIGNATURE <u>Clifford L. Hanna</u>

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02723

02716

1 PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Same b. COUNTY Same			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn				c. LENGTH OF STAY IN 1b 50 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 2 Box 160				e. STREET ADDRESS Same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Junior E. Oliver				4. DATE OF DEATH Month March Day 2rd. Year 1962			
5 SEX M	6. COLOR OR RACE C	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/1/90		9. AGE (In years lost birthday) yrs. 72	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer.			10b. KIND OF BUSINESS OR INDUSTRY Severn, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Jonas Oliver			14. MOTHER'S MAIDEN NAME Augusta Gaither				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-10-9990		17. INFORMANT Miss Eloise Oliver (daughter)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 2/22/62 19 to 3/2/62 19, that (I) (we) last saw the deceased alive on 2/22/62 19, and that death occurred 6:30 AM from the causes and on the date stated above.							
22a. SIGNATURE Gustave H. Faubert, M.D.				22b. ADDRESS Glen Burnie, Md.		22c. PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3/5/62		23c. NAME OF CEMETERY OR CREMATORY Brooklyn Md		23d. LOCATION (City, town, or county) (State) Brooklyn Md	
24. FUNERAL DIRECTOR'S SIGNATURE Chas. S. Wilson				25a. REC'D BY REGISTRAR DATE 5 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02724					02717				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE		b. COUNTY		
ANNE ARUNDEL		MARYLAND			MD		ANNE ARUNDEL		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
PASADENA		44 yrs			PASADENA		WOODS ROAD Box 392		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
WOODS ROAD - Box 392									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last					Month Day Year				
RACHEL PARKER					3 13 1962				
5. SEX					6. COLOR OR RACE				
Female					Colored				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH				
					2/14/1884				
9. AGE (in years last birthday) yrs.					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				
78					HOMEMAKER				
11. BIRTHPLACE (County & State, or foreign country)					12. CITIZEN OF WHAT COUNTRY?				
CALVERT Co MD					U.S.A.				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
WILLIAM BOONE					JANE THOMAS				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO.				
NO					NONE				
17. INFORMANT					Address				
MAGGIE JOHNSON					PASADENA MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)									
170X DUE TO Carcinoma of the left breast									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic carcinoma									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
none									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year									
Hour a.m. p.m. 19									
2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
2Df. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from... July 15, 1950 to March 13, 1962, that (I) (we) last saw the deceased alive on March 12, 1962, and that death occurred at 8 P.M. from the causes and on the date stated above.									
22a. SIGNATURE									
R.M. McLaughlin									
22b. DATE SIGNED									
March 13, 1962									
22c. PHYSICIAN'S NAME (Type)									
R.M. McLaughlin									
22d. ADDRESS									
8708 Mountain Rd Pasadena, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)									
Burial									
23b. DATE THEREOF									
3/18/1962									
23c. NAME OF CEMETERY OR CREMATORY									
Mt Zion M.E. Church									
23d. LOCATION (City, town or county) (State)									
MAGOTHY MD									
24. FUNERAL DIRECTOR'S SIGNATURE									
ADDRESS									
Mansour P. Hays 638 N. Gilman St									
25a. REC'D BY REGISTRAR									
25b. REGISTRAR'S SIGNATURE									
DATE 15 '62									
Caroline S. Thomas									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02725

Item 9 Film G310 4/2/62 mh

02718

PLACE OF DEATH
a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Annapolis

c. LENGTH OF STAY IN b

23 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Anne Arundel General Hospital

3. NAME OF DECEASED
(Type or print)

Susan

PARKER

DATE OF DEATH

March

20

1962

5. SEX

Female

Negro

6. COLOR OR RACE

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

Jan. Year UNKNOWN

19. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours Min.

74 Approx.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State or foreign country)

Galesville, Md

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John H. Davis

14. MOTHER'S MAIDEN NAME

Susan Turner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Gertrude Parker 452 W. 149th St + Apt 4 NY 31 NY

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

3 21 X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(b)
(c)

Coronary-vascular Disease

INTERVAL BETWEEN ONSET AND DEATH
25 days

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (do not) attended the deceased from Feb. 25, 1962 to Mar. 20, 1962, that (I) (do not) saw the deceased alive on Mar. 20, 1962, and that death occurred at M. from the causes and on the date stated above.

22a. SIGNATURE

A. T. Allen

ATTENDING PHYS. ☒

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

3/22/62

22c. PHYSICIAN'S NAME (Type)

A. T. Allen

22d. ADDRESS

62 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REINTERMENT (Specify)

Burial

23b. DATE THEREOF

3-24-62

23c. NAME OF CEMETERY OR CREMATORY

Our Lady of Sorrows

23d. LOCATION (City, town or county)

Owensville

(State)

Md

24. FUNERAL DIRECTOR'S SIGNATURE

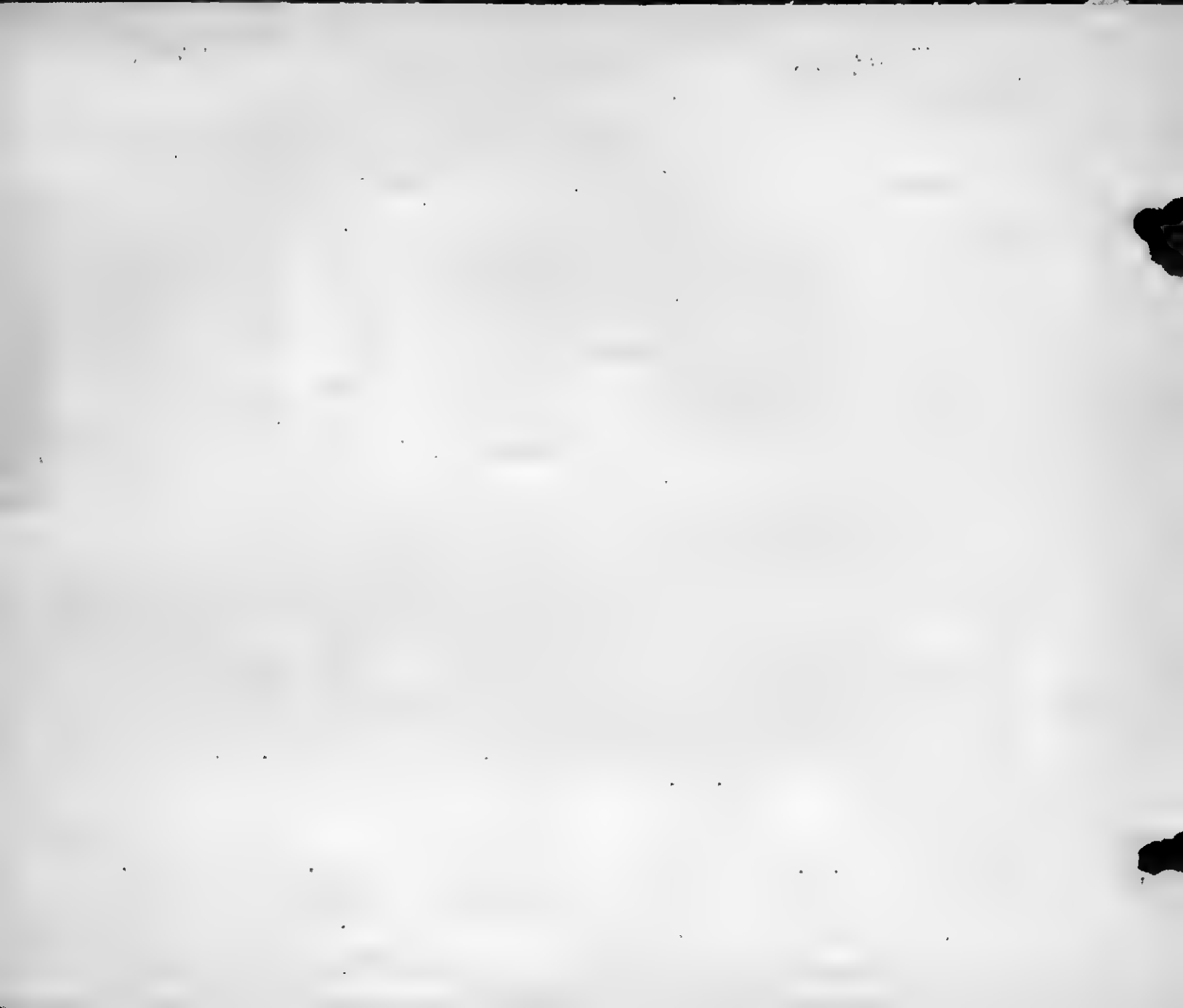
T A Hardesty + Son Galesville

ADDRESS

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE MAR 27 '62

Christina L. Thomas



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02719

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis - MD</u> c. LENGTH OF STAY in lb <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Anne Arundel Gen.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANCO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA - MD</u> d. STREET ADDRESS <u>601 Ritchie Hwy. Rt. 9 Box 363</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Jacob</u> First <u>L</u> Middle <u>PARKS.</u> Last		4. DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>1962</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>23 July 1925</u> 9. AGE (In years last birthday) <u>36</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trucker</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John F. Parks, Sr.</u> 14. MOTHER'S MAIDEN NAME <u>Ethel M. Carney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or department service) <u>WW2</u> 16. SOCIAL SECURITY NO. <u>219-10-3024</u>		17. INFORMANT <u>Mrs. Helen G. Parks</u> Address <u>Same As #2</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Myeloma</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Auto struck by tractor trailer of R. R. Burns</u>					
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>o. m.</u> <u>p. m.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhardt</u> EXAMINER'S NAME (Type) <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>MAR - 19 / 62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>22 March 62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u> 22d. LOCATION (City, town, or county) _____ (State) _____ <u>Glen Burnie, Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>R. R. Burns</u> <u>Glen Burnie Md.</u> 24a. REC'D BY REGISTRAR <u>DATE MAR 23 '62</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>			

TO DEPT. OF MEDICAL EXAMINER: This certificate should be returned within 24 hours after death. If any changes are necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02720

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY N 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>186 Gloucester St.</u>		2. USUAL RESIDENCE (Where deceased lived, if last location: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>186 Gloucester St.</u>	
3. NAME OF DECEASED (Type or print) <u>Dorothy</u> First <u>Patterson</u> Middle <u>Patterson</u> Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>3-18-1897</u> 9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>		4. DATE OF DEATH <u>March 25</u> 19 <u>62</u> 10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Stenographer State Gov't.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>USA</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clinton N. Patterson</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>#2</u> 17. INFORMANT <u>Marie L. Theodore</u> Address <u>#2</u>		18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>20.1</u> (c) <u>20.1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Unknown</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.) 20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town, (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 5, 1962</u> to <u>Jan 12, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 12, 1962</u> and that death occurred at <u>1:50 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James R. Martin</u> 22c. PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>		22b. DATE SIGNED <u>3-26-62</u> 22d. ADDRESS <u>6 SHAW ST. ANNAPOLIS, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3-28-1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 27 '62</u> 25b. REGISTRAR'S SIGNATURE <u>William A. Hines</u>	

1
24 hours after
the death
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

027228 Item 7 Film 0310 4/2/62 mn 02721

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN b 3 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - Crownsville
d. STREET ADDRESS Rt-1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) William Paddicord
First Middle Last
4. DATE OF DEATH March 25 1962
Month Day Year
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ DATE OF BIRTH May 23, 1878
8. WIDOWED ☒ DIVORCED ☐ 9. AGE (In years last birthday) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Maryland U.S.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Michael T. Paddicord 14. MOTHER'S MAIDEN NAME Mary Etta Stavfer
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e) Premia
DUE TO (b) Small Intersceral Reprovascular
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) Atherosclerotic Heart Disease
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: March 21, 1962, to March 24, 1962, that (I) (we) last saw the deceased alive on Mar. 24, 1962, and that death occurred at 2:45 AM from the causes and on the date stated above.
20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (we) attended the deceased from March 21, 1962, to March 24, 1962, that (I) (we) last saw the deceased alive on Mar. 24, 1962, and that death occurred at 2:45 AM from the causes and on the date stated above.
22a. SIGNATURE Edward S. Beck M.D. 22b. DATE SIGNED 3/26/62
22c. PHYSICIAN'S NAME (Type) Edward S. BECK, M.D. 22d. ADDRESS 71 Franklin St., Annapolis, Md.
23a. BURIAL, CREMATION, 23b. DATE THEREOF Mar. 28, 1962 23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery 23d. LOCATION (City, town or county) Annapolis, Maryland (State)
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hopping Funeral Home Annapolis, Md. 25a. REC'D BY REGISTRAR DATE MAR 29 '62 25b. REGISTRAR'S SIGNATURE Charles S. Kline

TO BE COMPLETED BY THE REGISTRAR PRIOR TO BURIAL, CREMATION, OR REMOVAL. THE LOW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 24 HOURS OF THE DEATH. PAGE 4 OF 4. TO FUNERAL DIRECTOR: AFTER THIS CERTIFICATE HAS BEEN SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETELY FILLED IN BY THE FUNERAL DIRECTOR, PAGE 3 SHOULD BE DETACHED FOR USE AS THE BURIAL-TRANSIT PERMIT. THEN PLEASE REMOVE CARBON PAPERS. PAGES 1 AND 2 SHOULD BE FILED WITH THE REGISTRAR PRIOR TO BURIAL, CREMATION, OR REMOVAL, AND IN ANY EVENT WITHIN 72 HOURS AFTER DEATH.

VS A15 (4)
15M 9/58

02722

CERTIFICATE OF DEATH

02722

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade		c. LENGTH OF STAY IN 1b -	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Kimbrough Army Hospital		d. STREET ADDRESS 5969 Benton Heights	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Wilbur Middle J Last Pessagno		4. DATE OF DEATH Month March Day 25 Year 19 62	
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1935
9. AGE (in years lost birthday) 26 yrs.		10. IF UNDER 1 YEAR: Months 26 Days 25 Hours 19 Min. 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY US Army	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert L. Pessagno, Jr.		14. MOTHER'S MAIDEN NAME Marie Zell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. Medical Records KAH Ft Geo G. Meade, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia, left lower lobe, etiology unk 491 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - DUE TO (c) -		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from xx 25 Mar 1962 , that I last saw the deceased alive on 24 Mar 1962 , and that death occurred at 1:48 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Kimbrough AH Ft Geo G. Meade, Md DATE SIGNED 25 Mar 62			
ACTUAL SIGNATURE McFrank md.		M.D. Kimbrough AH Ft Geo G. Meade, Md	
PHYSICIAN'S NAME (Type) MAX C. FRANK, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 3-29-62	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery Baltimore, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE L. J. Ruck Inc. 5305 Harford Road		ADDRESS	
24a. REC'D BY REGISTRAR DATE MAR 27 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02730

02723

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>124 S. Villa Ave</u>		d. STREET ADDRESS <u>124 S. Villa Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Georgetta Peterson</u>		4. DATE OF DEATH Month <u>3</u> Day <u>24</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-17-1890</u>
9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>72</u> Days <u>72</u> Hours <u>72</u> Min. <u>72</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lloyd Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no) <u>NO</u>		16. SOCIAL SECURITY NO. <u>James C. Chelant</u>	
17. INFORMANT <u>James C. Chelant</u>		Address <u>124 S. Villa Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Canceroma / Euphorus</u> 15c. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-10-62</u> to <u>3-24-62</u> that (I) (we) last saw the deceased alive on <u>3-10-62</u> 19 <u>62</u> and that death occurred at <u>10:5</u> M, from the causes and on the date stated above			
22a. SIGNATURE <u>A. T. Allen</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>		22d. ADDRESS <u>6 L Cathedral St</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-28-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Keese</u>		25a. REC'D BY REGISTRAR <u>W. P. Hanna</u>	
ADDRESS <u>Annapolis Md</u>		25b. REGISTRAR'S SIGNATURE	
DATE <u>MAR 23 '62</u>			

CERTIFICATE OF DEATH

02731

02724

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN b. <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Worton</u> d. STREET ADDRESS <u>Worton, R.F.D.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Phillips</u> Last <u>Phillips</u>		4. DATE OF DEATH Month <u>3</u> Day <u>20</u> Year <u>1962</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 10, 1877</u> 9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR: Months <u>14</u> Days <u>8</u> IF UNDER 24 HRS.: Hours <u>2</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Various</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown John Phillips</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>218-07-0793</u> 17. INFORMANT <u>Hospital Records</u> Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Myocardial Disease</u> (b) <u>Coronary Arteriosclerosis</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e) <u>Chronic Brain Syndrome Associated with Generalized & Cerebral Arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____ (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>3/19</u> to <u>3/20</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>3/20</u> , and that death occurred at <u>12P.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> M.D.		22b. DATE SIGNED <u>3/20/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL, CREMATION, etc. <u>Burial</u> 23b. DATE THEREOF <u>3/24/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Worton Point Cem.</u>	
23d. LOCATION (City, town or county) <u>RFD Worton, Md.</u> (State) _____		24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS _____	
25a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>MAR 27 '62</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXAMINED WITHIN 24 HOURS AFTER THE DEATH. THE FUNERAL DIRECTOR OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after the death. The funeral director or attending physician has been signed by the attending physician and completely filled in by the funeral director. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
02732		02725							
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel County</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel Co.</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>				c. LENGTH OF STAY IN 1b <u>2 mo.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>		d. STREET ADDRESS <u>Smith's Trailer</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Smith's Trailer</u>				First Middle Last		4. DATE OF DEATH <u>March 13, 1962</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>THERESA A. PINKERMAN</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-16-62</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		9. AGE (in years last birthday) <u>1</u> yrs. <u>27</u> months <u>27</u> days <u></u> hours <u></u> min.		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Larry Pinkerman</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Siller</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Larry Pinkerman</u> Address <u>Clover</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interstitial Pneumonitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>25X</u>									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Dronton</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <u>Howard G. Shaub</u> M.D. EXAMINER'S NAME (Type) <u>HOWARD G. SHAUB, M.D.</u> Address (Street, city, town, or county) <u>March 13, 1962</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>3/14/62</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Centenary Cem.</u> 22d. LOCATION (City, town, or country) (State) <u>Dronton Ohio</u> 23. FUNERAL DIRECTOR <u>Robert A. Barranco - Severna Park, Md.</u> ADDRESS 24. REC'D BY REGISTRAR <u>March 15 '62</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>									

2-102156

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
ma obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02733

02726

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 5 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Catherine Middle Pratt Last 4. DATE OF DEATH March 7, 1962		5. SEX Female 6. COLOR OR RACE Colored 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 7-8-1870 9. AGE (In years last birthday) 91 yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY: Own home 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None 17. INFORMANT Mr. Boston D.P.W. A.A. Co. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.V.A. 1957 Diabetes mellitus.		INTERVAL BETWEEN ONSET AND DEATH Over 5 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 6, 1960 to 3-3-1962 , 19____, that (I) (we) last saw the deceased alive on March 3, 1962 , and that death occurred at 11 M, from the causes and on the date stated above.			
22a. SIGNATURE James M. Pair M.D.		22b. ADDRESS 400 N. Carrollton Ave. Balto. 23, Md.	
22c. PHYSICIAN'S NAME (Type) James M. Pair, M.D.		22d. ADDRESS 400 N. Carrollton Ave. Balto. 23, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-10-62	
23c. NAME OF CEMETERY OR CREMATORY Magothy A.M.E.		23d. LOCATION (City, town, or county) 135 Arden (State) 1461	
24. FUNERAL DIRECTOR'S SIGNATURE Jackson Funeral Home ADDRESS		25a. REC'D BY REGISTRAR DATE 3-7-62 25b. REGISTRAR'S SIGNATURE Arthur L. Kincaid	

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02734

CERTIFICATE OF DEATH

Reg. Dist. No. 02727

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port George G. Meade</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lansdowne</u>			
c. LENGTH OF STAY IN 1b <u>22 hrs</u>				d. STREET ADDRESS <u>405 Bigley Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kimbrough Army Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>DAVID</u> Last <u>PRITCHARD</u>				4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>19 62</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>16 Feb 62</u>	
9. AGE (in years last birthday) yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rufus Pritchard</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Seivert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		INFORMANT Address <u>Father 405 Bigley Ave Lansdowne, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Circulatory and respiratory collapse, etiology</u> <u>773.5</u> DUE TO <u>unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs 54 mins</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prematurity, pyoderma, conjunctivitis, submaxillary abscess</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>16 Feb</u> , 19 <u>62</u> to <u>10 Mar</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>10 Mar</u> , 19 <u>62</u> , and that death occurred at <u>11:56 PM</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Kimbrough AH Ft Geo G. Meade, Md</u> DATE SIGNED <u>10 Mar 62</u>							
ACTUAL SIGNATURE <u>Stuart M. Bernstein</u> M.D.				PHYSICIAN'S NAME (Type) <u>STUART M. BERNSTEIN, Capt., M.C.</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/15/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Earl B. Holmstrom</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 22 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

02735

CERTIFICATE OF DEATH

Reg. Dist. No. 02728

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A.A. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Pasadena			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Duvall Highway, Pasadena, Md.				d. STREET ADDRESS Duvall Highway			
3. NAME OF DECEASED (Type or print) ERNESTINE First ROSSMEISL Middle ROSSMEISL Last				4. DATE OF DEATH Month MARCH Day 6 Year 1962			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 6, 1880	
9. AGE (In years lost birthday) 81 yrs.		IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.		IF UNDER 24 HRS. Months 10 Days 10 Hours 10 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY North Carolina		11. BIRTHPLACE (State or foreign country) U. S. A.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME George Wehnert				14. MOTHER'S MAIDEN NAME Annie Krause			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Charles Rossmeisl, Duvall Highway, Pasadena, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4-2-2-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1950 , 19____, to 3/6 , 19 62 , that I last saw the deceased alive on 3/2 , 19 62 , and that death occurred at 10:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Brady Smith M.D.				ADDRESS (Street, City or town, state) 9471 7th Avenue, Md.			
DATE SIGNED 3/6/62							
PHYSICIAN'S NAME (Type) J. BRADY SMITH				Pasadena, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/9/62		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Avenue #29				24a. REC'D BY REGISTRAR DATE MAR 8 '62		24b. REGISTRAR'S SIGNATURE C. A. L. Jones	

TO HAVE VALIDITY FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO BE FILLED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02735

02729

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN TB 9 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1516 Druid Hill Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary First Middle Last Mary L. Scott		4. DATE OF DEATH Month Day Year 3/ 11/ 1962	
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month Day Year 1876	
9. AGE last birthday 85 yrs		10. IF UNDER 1 YEAR Months Days 3 11 4	
11. IF UNDER 24 HRS. Hours Min. 19 62		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		13b. KIND OF BUSINESS OR INDUSTRY Home	
14. BIRTHPLACE (County & State, or foreign country) Baltimore Md.		15. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. FATHER'S NAME Jerome Hackett		17. MOTHER'S MAIDEN NAME Amy Carpenter	
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		19. SOCIAL SECURITY NO. Unknown	
20. INFORMANT Hospital Records		21. ADDRESS Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 334X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) _____ Uremia Arteriosclerotic Brain Disease Senility 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from 3/2 19 62 , to 3/11 19 62 , that (I) (we) last saw the deceased alive on 3/11 19 62 , and that death occurred at 2P M, from the causes and on the date stated above.			
22a. SIGNATURE Lionel McHenry Mapp, M. D.		22b. DATE 3/12/62	
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial 3/15/62		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	
23d. LOCATION (City, town or county) Baltimore Maryland		(State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE Herbert E. Smith		25a. REC'D BY REGISTRAR MAR 16 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Harris		DATE MAR 16 '62	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02730

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN IT d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS Cedar Park Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edward C. Sears		4. DATE OF DEATH March 9 1962		5. SEX Male 6. COLOR OR RACE White			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/26/1875		9. AGE (In years last birthday) 86 rs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired caretaker		10b. KIND OF BUSINESS OR INDUSTRY Development		11. BIRTHPLACE (County & State, or foreign country) Annapolis, Maryland			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Wesley C. Sears		14. MOTHER'S MAIDEN NAME Mary A. Wood			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214 182781		17. INFORMANT Files			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular insufficiency DUE TO (b) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from, 19... to 19... that (I) (we) last saw the deceased alive on 19... and that death occurred at...M, from the causes and on the date stated above.							
22a. SIGNATURE Richard I. Hochman		22b. ADDRESS Franklin Street, Annapolis, Maryland		22c. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.		22d. ADDRESS		22e. DATE SIGNED			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF March 13, 62		23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery			
23d. LOCATION (Town or county) Annapolis, Maryland		(State)		23e. REC'D BY REGISTRAR			
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		24b. ADDRESS Annapolis, Md.		25a. REGISTRAR'S SIGNATURE Arthur S. Hines			
25b. DATE MAR 13 '62		25c. REGISTRAR'S SIGNATURE					

TO FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02738

02731

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mayo</u> d. STREET ADDRESS <u>*****</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>ROBERT - GOSLIN SIMPSON</u>		4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1962</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 22, 1881</u>		9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Master Teaser</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Glass</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Fayette City, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Samuel Simpson</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>191-01-2093</u>		17. INFORMANT <u>Mr. Kenneth P. Simpson - Son</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. Myocardial infarction</u> (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) <u> </u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY: Hour <u> </u> s.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u> 19 <u> </u> 20d. INJURY OCCURRED: White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that (I) (this hospital) attended the deceased from <u>3/22/62</u> to <u>3/24/62</u> that (I) (we) last saw the deceased alive on <u>3/22/62</u> and that death occurred on <u>3/24/62</u> from the causes and on the date stated above,			
22a. SIGNATURE <u>Richard N. Peeler</u>				22b. DATE SIGNED <u>March 25, 1962</u>		22c. PHYSICIAN'S NAME (Type) <u>Richard N. Peeler</u>		22d. ADDRESS <u>121 Cathedral St. Annapolis, Md.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal - Burial</u>	
23b. DATE THEREOF <u>March 25, 62</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Bell Vernon Cemetery</u>		23d. LOCATION (City, town or county) <u>Bell Vernon, Pa.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Dropping Funeral Home</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 27 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinne</u>				25c. ADDRESS <u>Annapolis, Md.</u>		25d. ADDRESS <u> </u>		25e. ADDRESS <u> </u>		25f. ADDRESS <u> </u>	

TO BE FILLED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed by a physician who is 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02739 02732
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>17 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL - Harwood</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Helen</u> <u>SKARZYNSKI</u> F rst Middle Last 4. DATE OF DEATH <u>March</u> <u>20</u> <u>1962</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 14, 1890</u> 9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (County & State, or foreign country) <u>Poland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Matthew Zajac</u> 14. MOTHER'S MAIDEN NAME <u>Rosalie Sieniecki</u> Address <u>Bronislaw Skarzynski -Harwood, Md. A.A.Co.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>Bronislaw Skarzynski -Harwood, Md. A.A.Co.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (e) <u>Cerebral embolism</u> <u>7-3-3-0-1</u> DUE TO <u>Auricular fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) _____ INTERVAL BETWEEN ONSET AND DEATH <u>30 MIN</u> <u>6 WKS</u> <u>1 YRS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER!) _____ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____		20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>6:12 PM</u> a.m. p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (Dr. Richard N. Peeler) attended the deceased from <u>3/20</u> , 19 <u>62</u> to <u>Mar. 20, 1962</u> , that (I) (Dr. Peeler) last saw the deceased alive on <u>3/20</u> , 19 <u>62</u> and that death occurred at <u>6:12 PM</u> , from the causes and on the date stated above. 21a. SIGNATURE <u>Richard N. Peeler</u> M.D. 21b. DATE SIGNED <u>3/20/62</u>		22a. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. ADDRESS <u>121 Cathedral St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3/24/62</u> 23c. NAME OF CEMETERY <u>St. Stanislaus Cemetery</u> 23d. LOCATION (City, town or county) <u>6515 Boston St-Baltimore, Md.</u> (State) _____		24. FUNERAL DIRECTOR'S SIGNATURE <u>George A. Weber</u> 25a. REC'D BY REGISTRAR <u>MAR 23 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanes</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>George A. Weber</u> 705 South Ann Street			

02740

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

027833

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 38 Larken Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KIRBY		Last STEWART		4. DATE OF DEATH Month March Day 20 Year 1962	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. DATE OF BIRTH 1-27-1898		9. AGE (years IF UNDER 1 YEAR IF UNDER 24 HRS. lost b. day) Months Days Hours Min. 64		10a. USUAL OCCUPATION (Give kind of work done during normal working life, even if retired) Retired	
10b. R. OF BUSINESS OR INDUSTRY		11. PLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Emery Stewart		14. MOTHER'S MAIDEN NAME Mamie Stewart		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes W.W.I.	
16. SOCIAL SECURITY NO.		17. INFORMANT Katie Stewart		Address 514 4th St. Eastport	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Partial	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Petty		M.D. Charles S. Petty, M.D.		DATE SIGNED 3/21/62	
EXAMINER'S NAME (Type) William Reese		FURNERAL DIRECTOR William Reese		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 3-24-62		22c. NAME OF CEMETERY OR CREMATORY Pine Lawn		22d. LOCATION (City, town, or country) (State) Besgate Md.	
24a. REC'D BY REGISTRAR MAR 27 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02741

02734

1. PLACE OF DEATH a. COUNTY <u>aa</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MD</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>85 Shipwrought St.</u>		d. STREET ADDRESS <u>85 Shipwrought</u>	
3. NAME OF DECEASED (Type or print) <u>1 Henry Francis Sturdy</u>		4. DATE OF DEATH Month <u>Mar</u> Day <u>23</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-17-1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Prof. U.S. Naval Academy Teaching</u>		11. BIRTHPLACE (County & State or foreign country) <u>Washington, D.C. U.S.A.</u>	
13. FATHER'S NAME <u>Edward M. Sturdy</u>		14. MOTHER'S MAIDEN NAME <u>Edith Lockwood</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>John Chambliss</u> 17. INFORMANT Address <u>#2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DU TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic C.V.D.</u> (c) <u>DU TO</u> cause last, (c) <u>DU TO</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>Do 4</u> <u>yr.</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> e.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 10, 1960</u> to <u>3.23.62</u> , that (I) (we) last saw the deceased alive on <u>1.9.1962</u> , and that death occurred <u>SD</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Frank M. Shipley</u>		22b. DATE SIGNED <u>3.26.62</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK M. SHIPLEY</u>		22d. ADDRESS <u>Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
<u>Burial</u>	<u>Mar 27-62</u>	<u>Naval Academy</u>	<u>Annapolis Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 27 '62</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur A. Hines</u>	

TO FINAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MEDICAL CERTIFICATION

<div> <div>1</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>02742</div> <div>02735</div> </div> <div> <div>FOR STATE HEALTH DEPT.</div> <div> <div>TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.</div> <div>TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.</div> </div> <div>VS. A15ME SM 9/60</div> </div>										<div> <div>HEALTH DEPT.</div> <div> <div>TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.</div> <div>TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.</div> </div> <div>VS. A15ME SM 9/60</div> </div>									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Co.</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>														
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY in 1b <u>life</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>			d. STREET ADDRESS <u>Box 16 - Bay Ridge Road</u>											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) <u>EARL</u> <u>L.</u> <u>SURGEON</u>					4. DATE OF DEATH <u>March</u> <u>15</u> <u>1962</u>														
5. SEX <u>male</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 20 - 1910</u>		9. AGE (In years last birthday) <u>52</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen. Utilities</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>*****</u>		11. BIRTHPLACE (State or foreign country) <u>A.A.Co. Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>Thomas Surgeon</u>					14. MOTHER'S MAIDEN NAME <u>Rachel Grayson</u>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Louise Wise-107 LaRue Square, Balt. Md.</u>														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound left chest with hemothorax</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u> </u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)															
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)								
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input type="checkbox"/> <u>Accident</u> <input type="checkbox"/> <u>Suicide</u> <input type="checkbox"/> <u>Homicide</u> <input checked="" type="checkbox"/> <u>Undetermined manner</u> <input type="checkbox"/>																			
ACTUAL SIGNATURE <u>Rudiger Breitenecker</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <u>March 16, 1962</u>											
EXAMINER'S NAME (Type) <u>Rudiger Breitenecker, M.D.</u>					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>3-20-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Annapolis - Neck</u>			22d. LOCATION (City, town, or country) (State) <u>Annapolis, Maryland</u>									
23. FUNERAL DIRECTOR <u>C.E. Hicks III</u>					ADDRESS <u>Annapolis, Maryland</u>			24a. REC'D BY REGISTRAR <u>MAR 23 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>									

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02743

Item 12-111M-1215 3/21/62 iwk

02736

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1012 Rose Ann Avenue				e. STREET ADDRESS 1012 Rose Ann Avenue			
3 NAME OF DECEASED (Type or print) First John Middle Joseph Last Thomas				4. DATE OF DEATH Month March Day 12 Year 19 62			
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct., 20, 1900	
9. AGE (In years lost birthday) 61 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician				10b. KIND OF BUSINESS OR INDUSTRY Standard Oil Co.		11 BIRTHPLACE (State or foreign country) Poland	
12 CITIZEN OF WHAT COUNTRY? U.S.A.							
13 FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16 SOCIAL SECURITY NO 214-01-4337		17 INFORMANT Eunice Thomas, Same as 1.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO (c) Senility							INTERVAL BETWEEN ONSET AND DEATH 3 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/5 19 59 to 3/11 19 62 , that (I) (we) last saw the deceased alive on 3/6 19 62 , and that death occurred at M , from the causes and on the date stated above							
22a. SIGNATURE R. W. Prichard				ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22d. ADDRESS 715 Cotter Rd., Glen Burnie, Md.		22b. DATE SIGNED 3/14/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/15/62		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		23d. LOCATION (City, town, or county) (State) Balto. County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping & Kirkley F. H.				25a. REC'D BY REGISTRAR 3/16/62		25b. REGISTRAR'S SIGNATURE C. S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02744

02737

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN it <u>2 Yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not an hospital, give street address) <u>Plaza Manor Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admision) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>1031 West Fayette Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u>		4. DATE OF DEATH Last <u>THOMAS</u> Month <u>March</u> Day <u>19</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 10, 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		11. BIRTHPLACE (Country & State, or foreign country) <u>North Carolina</u>	
13. FATHER'S NAME <u>JORDON</u>		14. MOTHER'S MAIDEN NAME <u>AGELINE CLANDON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-10-9854</u>	
17. INFORMANT <u>CHANEY CUNNINGHAM</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> DUE TO (b) <u>Senility</u> DUE TO (c) <u>Cerebral and Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac Decompensation</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) <u>Osteo Arthritis</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Decubitus Ulcers</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/1/62</u> to <u>3/19/62</u> that (I) (we) last saw the deceased alive on <u>3/19/62</u> and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Lionel M. Henry Mapp</u>		22b. DATE SIGNED <u>3/19/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lionel M. Henry Mapp</u>		22d. ADDRESS <u>20 Dean St Annapolis Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/22/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Brooklyn A. G. C. M.</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Manfred P. Papp</u>		25a. REC'D BY REGISTRAR <u>MAR 20 1962</u>	
25b. REGISTRAR'S SIGNATURE <u>William L. Thomas</u>			

1
The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02745

02738

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Tobacco	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 2 mos. 9 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS Unknown	
3. NAME OF DECEASED (Type or print) First James Middle Dennis Last Thompson		4. DATE OF DEATH Month 3 Day 13 Year 19 62	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1887
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 7 Days 13	
11. IF UNDER 24 HRS. Hours 19 Min 62		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Thompson		14. MOTHER'S MAIDEN NAME Elizabeth	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Accident DUE TO Arteriosclerotic Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Associated with Above		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) ----- (County) ----- (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 1/14 to 3/13 , 19 62 , that (I) (we) last saw the deceased alive on 3/13 , 19 62 , and that death occurred at 7 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Hildegard Heard Reissman		22b. DATE SIGNED 3/14/62	
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M.D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) 18/20/62		23b. DATE THEREOF 18/20/62	
23c. NAME OF CEMETERY OR CREMATORY St. John's		23d. LOCATION (City, town or county) St. John's	
24. FUNERAL DIRECTOR'S SIGNATURE Brown & Davidson		25a. REC'D BY REGISTRAR DATE MAR 23 '62	
ADDRESS 5635 Eads St.		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ANNE ARUNDEL GENERAL HOSPITAL</u>											
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>OHIO</u> b. COUNTY <u>COLUMBUS</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>72 x 3</u> d. STREET ADDRESS <u>746 S. Chesterfield Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>QUENTIN VERNATTEE</u> 4. DATE OF DEATH <u>3 19 1962</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>10-21-22</u> 9. AGE (in years last birthday) <u>39</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u> 10b. MODERN OCCUPATION <u>Irs Trucking Co.</u> 11. BIRTHPLACE (State or foreign country) <u>West Va.</u> 12. CITIZEN OF WHAT COUNTRY											
13. FATHER'S NAME <u>Willard Vernetto</u> 14. MOTHER'S MAIDEN NAME <u>Elizabeth Vanover</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> 16. SOCIAL SECURITY NO. <u>WW2</u> 17. INFORMANT <u>Reger Funeral Home, Huntington W. Va.</u> Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemothorax and hemoperitoneum with rib fractures</u> <u>816x</u> DUE TO <u>and laceration of spleen</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary fat embolism</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of tractor-trailer in collision with car at traffic</u> 20c. TIME OF INJURY Hour a.m. <u>12:00</u> Month, Day, Year <u>3 19 1962</u> 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway (Dorr's Corner Anne Arundel Md.)</u> 20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Russell S. Fisher</u> M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>3-19-62</u> EXAMINER'S NAME (Type) <u>RUSSELL S. FISHER, M.D.</u> Address (Street, city, town, or county) <u>Huntington W. Va.</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> 22b. DATE THEREOF <u>Mar. 19/62</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Vanla Cem.</u> 22d. LOCATION (City, town, or country) (State) <u>Huntington W. Va.</u>											
23. FUNERAL DIRECTOR <u>St. James Funeral Home</u> ADDRESS <u>2024 Orleans Street</u> 24a. REC'D BY REGISTRAR <u>MAR 21 '62</u> 24b. REGISTRAR'S SIGNATURE <u>W. S. Thomas</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02747		02740	
1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md b. COUNTY AA	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasadena		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie	
c. LENGTH OF STAY in lb 15 MCH		d. STREET ADDRESS 216 Crain Highway N	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Day Nursing Home- Riveria Beach		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Birdie		4. DATE OF DEATH March 24 19 62	
5. SEX F		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 17, 1887	
9. AGE (In years last birthday) 74 yrs.		10. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry D. Wisner		14. MOTHER'S MAIDEN NAME Mary Wolf	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. James B. Sutherland, Box 164	
17. INFORMANT Glen Burnie		Address Glen Burnie	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Arteriosclerotic Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5 years DUE TO (b) 5 years DUE TO (c) 5 years		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 31, 1959 to March 24, 1962 ; that (I) (we) last saw the deceased alive on March 23, 1962 ; and that death occurred at 1 P.M. from the causes and on the date stated above.			
22a. SIGNATURE R. M. McLaughlin		22b. DATE SIGNED 3/24/62	
22c. PHYSICIAN'S NAME (Type) R. M. McLaughlin		22d. ADDRESS 3708 Mountain Rd. Pasadena, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/ 27/ 62	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town or county) (State) Baltimore 25. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkleyn		25a. REC'D BY REGISTRAR DATE MAR 28 '62	
ADDRESS Glen Burnie, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02748		02741	
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL - Pasadena</u>	
c. LENGTH OF STAY IN B <u>4 days</u>		d. STREET ADDRESS <u>Rt-9, Box-206 A</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ivie</u> Middle <u>WALKER</u> Last <u>March</u>		4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15, 1889</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Pete Hardin</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Hardin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Sadie Hall-Rt-9, Box-206-A-Pasadena, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u> 4-22 DUE TO (b) <u>arterio-sclerotic cardiovascular disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) INTERVAL BETWEEN ONSET AND DEATH <u>4 days (2 years)</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 18.)	
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <u>Edith Rodler</u> attended the deceased from <u>3-3-62</u> to <u>Mar. 7, 1962</u> , that (I) <u> </u> saw the deceased alive on <u>Mar. 7, 1962</u> , and that death occurred at <u>9:50 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Edith Rodler</u> M.D.		22b. DATE SIGNED <u>3/7/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edith Rodler, M.D.</u>		22d. ADDRESS <u>45 Franklin St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>3-9-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gastonia</u>	23d. LOCATION (City, town or county) (State) <u>North Carolina</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Brown & Son Montgomery</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 12 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Vane</u>			

108 W. Montgomery Street, Balto-30, Md.

1
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02749

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02742

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Co.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>13 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>116 Marie Avenue</u>		e. STREET ADDRESS <u>Same</u>	
3. NAME OF DECEASED (Type or print) <u>Marion J. Wasielewski</u>		4. DATE OF DEATH <u>March 3 1962</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/4/09</u>	
9. AGE (In years last birthday) <u>52 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Warsaw, Poland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Frank Wasielewski</u>		14. MOTHER'S MAIDEN NAME <u>Mary Janowiak</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT <u>Margaret Wasielewski (wife)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia secondary to convulsive seizure</u> <u>metal plate in skull with old brain damage</u> (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Convulsive seizure, back yard of home, with fall resulting in numerous contusions and abrasions of head, trunk and extremities</u>	
20c. TIME OF INJURY Month, Day, Year <u>6:30 AM Mar. 3 1962</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <u>at home</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>116 Marie Ave., Glenburnie, Md</u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Rudiger Breiteneker</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>March 3, 1962</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Rudiger Breiteneker, M.D.</u>		Address (Street, city, town, or county) <u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 6-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Burnie Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u>	
23. FUNERAL DIRECTOR <u>Edward A. ...</u>		24a. REC'D BY REGISTRAR <u> </u>	
24b. REGISTRAR'S SIGNATURE <u> </u>		DATE <u>Mar 6 '62</u>	

FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 and 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

DEPUTY MEDICAL EXAMINER: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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SM 9/60

Division of
02750

STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02243

02743

1. PLACE OF DEATH a. COUNTY		Anne Arundel County		MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Annapolis		c. LENGTH OF STAY IN 16	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		U.S. Navy Station			
3. NAME OF DECEASED (Type or print)		HERBERT A. WELLS		4. DATE OF DEATH Month Day Year March 20 19 62	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH 7/18/26	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Fireman		-Annapolis Naval Base		Brooklyn, N. Y.	
13. FATHER'S NAME		Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Evelyn Wells-1901 Norwich Road-Glen Burnie	
Yes		World War II			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Intoxication 892.6 Conditions, if any, which gave rise to immediate cause (b) Extensive Body Burns (c) DUE TO cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Died while fighting fire.			
20c. TIME OF INJURY Month, Day, Year Hour <input checked="" type="checkbox"/> p.m. 3/20 19 62		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. Naval Academy Annapolis Md	
20f. (City or town) Annapolis		20g. (County) Anne Arundel		20h. (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/21/62	
ACTUAL SIGNATURE Charles S. Petty		M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county) Paramus, New Jersey	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3-22-62		22c. NAME OF CEMETERY George Washington Memorial	
22d. LOCATION (City, town, or country) Paramus, New Jersey		22e. (State) New Jersey		22f. REGISTRAR'S SIGNATURE MAR 23 '62	
23. FUNERAL DIRECTOR J. J. ...		23a. ADDRESS 12 ...		23b. DATE MAR 23 '62	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 must be completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02751

02744

1. PLACE OF DEATH a. COUNTY AA MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bk. c. LENGTH OF STAY IN town 5208 Pat. Henry Dr. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5208 Pat. Henry Dr.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY AA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn d. STREET ADDRESS 5208 Pat. Henry Dr.	
3. NAME OF DECEASED (Type or print) First Margaret Middle A. Last Westcamp		4. DATE OF DEATH Month 3 Day 21 Year 1962	
5. SEX F		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/5/82	
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ld. Bito. Hotel		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Patrick Westcamp		14. MOTHER'S MAIDEN NAME Margaret McPhilips	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Family Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Hypertensive heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 11-24 , 19 61 , to 3-21 , 19 62 , that (I) (we) last saw the deceased alive on 3-21 , 19 62 , and that death occurred at 10 p.m., from the causes and on the date stated above. 22a. SIGNATURE Morton M. Kreiger 22c. PHYSICIAN'S NAME (Type) Morton M. Kreiger, M.D. 22b. DATE SIGNED 3/22/62 22d. ADDRESS 5010A Ritchie Hwy. Baltimore 25, Md 22e. REC'D BY REGISTRAR DATE MAR 28 '62 22f. REGISTRAR'S SIGNATURE James E. Thomas			
23a. BURIAL, CREMATION, REMOVAL (Specify) B		23b. DATE THEREOF 3/24/62	
23c. NAME OF CEMETERY OR CREMATORY Holy Red. Cem.		23d. LOCATION (City, town or county) (State) Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes		25. ADDRESS 13- E. Fort Ave. Balt.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY A.A. CO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE MD. b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WOODLAWN.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ANNE ARUNDEL HOSP.		d. STREET ADDRESS 6633 DOGWOOD RD.	
3. NAME OF DECEASED (Type or print) First FERD Middle R. Last WICKESSER		4. DATE OF DEATH Month MAR. Day 31 Year 1962	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 21, 1887
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 7 Days 4	
11. IF UNDER 24 HRS. Hours 7 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST, BALTO. BROOK CO.		10b. KIND OF BUSINESS OR INDUSTRY MD.	
13. FATHER'S NAME JOHN WICKESSER		14. MOTHER'S MAIDEN NAME SCHLERF	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. MR. FERD C. WICKESSER	
17. INFORMANT MR. FERD C. WICKESSER		Address 6633 DOGWOOD RD. BALTO. 7, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 3:31 p.m. Month, Day, Year 1962	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/31/62 19 ONLY , that (I) (we) last saw the deceased alive on 3/31 19 62 and that death occurred 5:10 PM from the causes and on the date stated above.			
22a. SIGNATURE Richard N. Peeler		22b. DATE SIGNED 3/31/62	
22c. PHYSICIAN'S NAME (Type) RICHARD N. PEELER		22d. ADDRESS ANNAPOLIS, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4/4/62	23c. NAME OF CEMETERY OR CREMATORY LOUDON PT. CEMT.	23d. LOCATION (City, town or county) (State) BALTO. MD.
24. FUNERAL DIRECTOR'S SIGNATURE WITKE, 4101 EDMONDSON AVE.		25a. REC'D BY REGISTRAR DATE APR 3 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

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UNITED STATES OF AMERICA

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